

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07008

07054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Bay Rd.				d. STREET ADDRESS 1 Bay Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN EDWARD ADOLPH, Jr.				4. DATE OF DEATH Month Day Year July 28, 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 23, 1910		9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY S. Kann & Sons		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John E. Adolph, Sr.				14. MOTHER'S MAIDEN NAME Lillian E. Spindler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World No. II 215-01-5192		17. INFORMANT Address Mr. John E. Adolph, Sr.-1 Bay Rd., Riviera Beach			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of prostata 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with widespread metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-26 , 19 57 , to 7-28 , 19 57 , that I last saw the deceased alive on 7-28 , 19 57 , and that death occurred at 8:30 p. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 441-A, PASADENA, Md DATE SIGNED 7-29-57							
ACTUAL SIGNATURE Otto Vogel MD		M.D. OTTO VOGEL, M.D.					
PHYSICIAN'S NAME (Type) OTTO VOGEL, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens Sons - Balt. Md.				24a. REC'D BY REGISTRAR DATE 7/31/57		24b. REGISTRAR'S SIGNATURE L. J. Dealy	

BUREAU V. S.

1957 1 AUG

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07009

Reg. Dist. No.

07055

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Gambrills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Davidsonville Road				d. STREET ADDRESS Davidsonville Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA STERLING ANDERSON				4. DATE OF DEATH Month JULY Day 24 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1870		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown LOTT				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. George W. Sterling Jr. Son same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.3 DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes					
20c. TIME OF INJURY Month, Day, Year Hour XXXX p. m. 7-24-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Gambrills, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Elmer G. Linhardt				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Elmer G. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 24, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				24. REC'D BY REGISTRAR July 29 1957 REGISTRAR'S SIGNATURE L. M. Jaynes			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07056

CERTIFICATE OF DEATH

Reg. Dist. No.

07011

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY AA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #1 B	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION BEACH WOOD ON THE BURLEY		d. STREET ADDRESS #1 D	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROSA ISABELLA BENFIELD		4. DATE OF DEATH Month Day Year JULY 6 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 25 1865
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) LEHIGH CO. PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LYNN		14. MOTHER'S MAIDEN NAME MARY (UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HERBERT C. YOUNG Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chronic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile changes		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1957 , to July 5, 1957 , that I last saw the deceased alive on July 5, 1957 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE T. G. De Ouedo M.D.			
PHYSICIAN'S NAME (Type) T. G. De Ouedo			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7-10-57	22c. NAME OF CEMETERY OR CREMATORY ZION-LEHIGH CHURCH CEM.	22d. LOCATION (City, town, or county) (State) Lehigh Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SONS ADDRESS ANNAPOLIS MD		24a. REC'D BY REGISTRAR 7/9/57	24b. REGISTRAR'S SIGNATURE J. O. Brown

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

070138

Reg. Dist. No.

07957

Item 8 Film 6218 8-6-57 et

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN lb <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> <u>X2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elvaton Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Edgar Bessick</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26th.</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/57 1915</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Millersville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bessick</u>				14. MOTHER'S MAIDEN NAME <u>Alverta Gatewood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-8128</u>		17. INFORMANT Address <u>Mrs. Delma Bessick (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchial Asthma</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>One week</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustavo H. Faubert</u>				DATE SIGNED <u>7/26/57</u>			
EXAMINER'S NAME (Type) <u>Gustavo H. Faubert, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/29/57</u>		<u>Mt Calvary</u>		<u>A & Co md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah L Brown</u>				24. REC'D BY REGISTRAR <u>J. M. Joyce</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

JUL 31 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07013

07058 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Potomac Pk.</u>		LENGTH OF STAY (in this place) <u>19</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		COUNTY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>202 Bishop Ave. Bldg 25</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Lucy Coleman Boulware</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cre.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 1882</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Maria</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Charlie Boulware (son)</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Carcinoma Descending Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>						<u>10 yrs -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-5-57</u>			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1940</u> to <u>7/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball</u>				ADDRESS (Street, city, town, state) <u>M.D. Littleton</u>		DATE SIGNED <u>7/25/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/29/57</u>		NAME OF CEMETERY OR CREMATORY <u>McCalvary</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. REC'D BY REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>—</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac L. Brown & Son</u>		ADDRESS <u>108 W. Montgomery St.</u>	
DATE <u>JUL 31 '57</u>							

CERTIFICATE OF DEATH

Form No. 100-1

1. Name of deceased (Print or write full name)

2. Sex

3. Race

4. Date of birth

5. Date of death

6. Place of death

7. Cause of death

8. Duration of illness

9. Usual residence of deceased

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Date of registration

14. Place of burial

15. Name of funeral home

16. Name of undertaker

17. Name of cemetery

18. Name of interment

19. Name of funeral home

20. Name of undertaker

21. Name of cemetery

22. Name of interment

23. Name of funeral home

24. Name of undertaker

25. Name of cemetery

26. Name of interment

27. Name of funeral home

28. Name of undertaker

29. Name of cemetery

30. Name of interment

31. Name of funeral home

32. Name of undertaker

33. Name of cemetery

34. Name of interment

35. Name of funeral home

36. Name of undertaker

37. Name of cemetery

38. Name of interment

39. Name of funeral home

40. Name of undertaker

41. Name of cemetery

42. Name of interment

43. Name of funeral home

44. Name of undertaker

45. Name of cemetery

46. Name of interment

47. Name of funeral home

48. Name of undertaker

49. Name of cemetery

50. Name of interment

51. Name of funeral home

52. Name of undertaker

53. Name of cemetery

54. Name of interment

55. Name of funeral home

56. Name of undertaker

57. Name of cemetery

58. Name of interment

59. Name of funeral home

60. Name of undertaker

61. Name of cemetery

62. Name of interment

63. Name of funeral home

64. Name of undertaker

65. Name of cemetery

66. Name of interment

67. Name of funeral home

68. Name of undertaker

69. Name of cemetery

70. Name of interment

71. Name of funeral home

72. Name of undertaker

73. Name of cemetery

74. Name of interment

75. Name of funeral home

76. Name of undertaker

77. Name of cemetery

78. Name of interment

79. Name of funeral home

80. Name of undertaker

81. Name of cemetery

82. Name of interment

83. Name of funeral home

84. Name of undertaker

85. Name of cemetery

86. Name of interment

87. Name of funeral home

88. Name of undertaker

89. Name of cemetery

90. Name of interment

91. Name of funeral home

92. Name of undertaker

93. Name of cemetery

94. Name of interment

95. Name of funeral home

96. Name of undertaker

97. Name of cemetery

98. Name of interment

99. Name of funeral home

100. Name of undertaker

101. Name of cemetery

102. Name of interment

103. Name of funeral home

104. Name of undertaker

105. Name of cemetery

106. Name of interment

107. Name of funeral home

108. Name of undertaker

109. Name of cemetery

110. Name of interment

111. Name of funeral home

112. Name of undertaker

113. Name of cemetery

114. Name of interment

115. Name of funeral home

116. Name of undertaker

117. Name of cemetery

118. Name of interment

119. Name of funeral home

120. Name of undertaker

121. Name of cemetery

122. Name of interment

123. Name of funeral home

124. Name of undertaker

125. Name of cemetery

126. Name of interment

127. Name of funeral home

128. Name of undertaker

129. Name of cemetery

130. Name of interment

RECEIVED

BUREAU V. 4

JUL 31 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

07023

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A A Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY BOY</u> Middle <u>BROWN</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-57</u> 1 day 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ALBERT F. BROWN, JR.</u>				14. MOTHER'S MAIDEN NAME <u>GRACE LOUISE THOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>FATHER #13</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>PREMATURITY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>ANNAPOLIS</u> (County) <u>MD</u> (State) <u>MD</u>				20g. (City or town) <u>ANNAPOLIS</u> (County) <u>MD</u> (State) <u>MD</u>			
21. I certify that I attended the deceased from <u>JULY 28, 1957</u> , to <u>JULY 28, 1957</u> , that I last saw the deceased alive on <u>JULY 28, 1957</u> , and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton Norton</u> M.D. <u>95</u>				ADDRESS (Street, city or town, state) <u>CATHERRAL</u> DATE SIGNED <u>7/30/57</u>			
PHYSICIAN'S NAME (Type) <u>CLAYTON NORTON</u>				ANNAPOLIS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>		22d. LOCATION (City, town, or county) <u>Annabopolis</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annabopolis MD</u>				24a. REC'D BY REGISTRAR <u>7/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>U. Orm</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063242xv1

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF MORTUARY		18. SIGNATURE OF BURIAL		19. SIGNATURE OF CREMATION		20. SIGNATURE OF OTHER	

RECEIVED
JUL 31 1957
BUREAU V. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07059

CERTIFICATE OF DEATH

07015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel Gardens (R)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel Gardens 50 (25)</u>	
c. LENGTH OF STAY IN 1b <u>About 8 mos.</u>		d. STREET ADDRESS <u>711 Cresswell Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>711 Cresswell Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>W.</u> Last <u>Burch</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hayes</u>		14. MOTHER'S MAIDEN NAME <u>Laura (?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry E. Burch, Jr. (son)</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage + Peripheral Vascular Collapse</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease & Failure</u> <u>332X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>3 wks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/6/57</u> , 19 <u>57</u> , to <u>7/25/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/19/57</u> , 19 <u>57</u> , and that death occurred at <u>12:50 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard H. Flax</u>		M.D. <u>113 7th Ave Brooklyn Park</u>	
PHYSICIAN'S NAME (Type) <u>Leonard H. Flax, M.D.</u>		DATE SIGNED <u>7/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 29-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Balto Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Evans</u>		ADDRESS <u>4005 Charles St. Balto</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>John Whitney</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled with handwritten text.

BUREAU V. S.

JUL 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 4 Film G218 7-22-57 et
07024
CERTIFICATE OF DEATH

07016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ind. x0</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Gen. Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>William Leonard Butler</i>		4. DATE OF DEATH <i>July 15, 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14, 1907</i>
9. AGE (In years last birthday) <i>50</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Barnes Butler</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Dorothy Swann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>William B Butler</i>	
17. INFORMANT <i>William B Butler</i>		Address <i>Mitchellville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Premature Birth</i> <i>776X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-14-57</i> 19 <i>8:30</i> <i>7-15-57</i> 19 <i>8:30</i> , that I last saw the deceased alive on <i>7-15-57</i> 19 <i>8:30</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. T. Allen</i>		DATE SIGNED <i>7-17-57</i>	
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		ADDRESS (Street, city or town, state) <i>62 Cathedral St</i>	
22a. BURIAL, CREMATION, or other disposition (Specify) <i>July 17/57</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Swann</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>18 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Wm J. Lundy</i>	

2063275 XV2

07060

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Be.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO RIVIERA BEACH.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREENWAY.</u>				d. STREET ADDRESS <u>GREENWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>Belle</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-13</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>GA.</u>	
13. FATHER'S NAME <u>Gould Thomas</u>				14. MOTHER'S MAIDEN NAME <u>CLARISSA Lloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family - Same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO <u>2 years</u> (c) <u>Atherosclerotic Cardio Vascular Disease</u> DUE TO <u>10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 19, 1957</u> , to <u>July 28, 1957</u> , that I last saw the deceased alive on <u>July 28, 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Riviera Beach, MD.</u> DATE SIGNED <u>7/29/57</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				ADDRESS <u>RIVIERA BEACH, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>7-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Campbell</u>		22d. LOCATION (City, town, or county) (State) <u>Seaside Shore, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCurry Funeral Home</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUL 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Decker</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07018

07061

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets RFD Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Margarets Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER OLIVER CARTER</u>				4. DATE OF DEATH Month Day Year <u>JULY 9 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>wholesale meats</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William H. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Susie Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I 215-18-9540</u>		17. INFORMANT <u>Mrs Agnes Carter- Wife- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 HRS</u> <u>10 YRS.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/9, 1957</u> , to <u>7/9, 1957</u> , that I last saw the deceased alive on <u>7/9, 1957</u> , and that death occurred at <u>5:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate Ave. Annapolis, Maryland</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. PHYSICIAN'S NAME (Type) <u>Edward S. Beck MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Margarets Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Margarets, A.A. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. French</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE		ALABAMA		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		TREATMENT		POST-MORTEM		CORONER'S OFFICE	
JUL 6 1968		MOBILE, ALABAMA		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		NO		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU A. 3

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours, after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07019

07062

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>P.A.</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>P.A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Jewell, md.</u>				TOWN <u>Jewell md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Octavia</u> <u>Coates</u>				<u>7</u> <u>12</u> <u>1957</u>			
5. SEX	6. (COLOR) OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>			<u>7</u>	<u>54</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>md</u> <u>P.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Harvey Wilkerson</u>				<u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Savannah Reid Jewell Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A)				<u>Acute cardiac decompensation</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertension CVR Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>2 hrs</u>			
				<u>10 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>4-3-53</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>30 June</u> <u>1957</u> to <u>July</u> <u>1957</u> that I last saw the deceased alive on <u>30 June</u> <u>1957</u> and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>[Signature]</u> M.D.				<u>Upper Marlboro Md</u> <u>12 July 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>7-14-57</u>		<u>Easters</u>		<u>Friendship</u> <u>MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>7-13-57</u>		<u>H. W. Ward</u>		<u>P.E. Sewell Jr. Fred, Md.</u>			
		<u>H. H. Hedrick</u>					

CERTIFICATE OF DEATH

MASSACHUSETTS

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. AGE

13. OCCUPATION

14. CAUSE OF DEATH

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. SEX

18. AGE

19. OCCUPATION

20. CAUSE OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. SEX

24. AGE

25. OCCUPATION

26. CAUSE OF DEATH

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. SEX

30. AGE

31. OCCUPATION

32. CAUSE OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. AGE

37. OCCUPATION

38. CAUSE OF DEATH

39. PLACE OF BIRTH

40. DATE OF BIRTH

41. SEX

42. AGE

43. OCCUPATION

44. CAUSE OF DEATH

45. PLACE OF BIRTH

46. DATE OF BIRTH

47. SEX

48. AGE

49. OCCUPATION

50. CAUSE OF DEATH

51. PLACE OF BIRTH

52. DATE OF BIRTH

53. SEX

54. AGE

55. OCCUPATION

56. CAUSE OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX

60. AGE

61. OCCUPATION

62. CAUSE OF DEATH

63. PLACE OF BIRTH

64. DATE OF BIRTH

65. SEX

66. AGE

67. OCCUPATION

68. CAUSE OF DEATH

69. PLACE OF BIRTH

70. DATE OF BIRTH

71. SEX

72. AGE

73. OCCUPATION

74. CAUSE OF DEATH

75. PLACE OF BIRTH

76. DATE OF BIRTH

77. SEX

78. AGE

79. OCCUPATION

80. CAUSE OF DEATH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX

84. AGE

85. OCCUPATION

86. CAUSE OF DEATH

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JUL 29 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07020

07063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b Since 6/57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 601 Stewart Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Catherine Middle Cole Last				4. DATE OF DEATH Month July Day 13th Year 1957			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/71	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME ? Eunich				14. MOTHER'S MAIDEN NAME ? Rebecca Ann Toner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ***** None		17. INFORMANT Address Mrs. Frederick Stranz (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 450.0							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6/2/57 , 19, to 7/13/57 , 19, that I last saw the deceased alive on 7/13/57 , 19, and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 7/14/57							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. Glen Burnie, Md.			
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/57		22c. NAME OF CEMETERY OR CREMATORY Louison Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR JUL 17 1957		24b. REGISTRAR'S SIGNATURE L. J. Dealy	

BUREAU V. S.

1957 17 JUL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07021

Reg. Dist. No. 21

07064

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferry Farm, P.O. Annapolis</u> c. LENGTH OF STAY IN 1b <u>Few minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Severn River</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3401-4</u> d. STREET ADDRESS <u>1824 Wilkens Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edgar Collins</u>				4. DATE OF DEATH Month Day Year <u>July 7th 1957</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/17/22</u>		9. AGE (In years last birthday) <u>34</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Princess Ann Md.</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Collins</u>				14. MOTHER'S MAIDEN NAME <u>Florence Revelle</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Prisoner 22 months 1942</u>				16. SOCIAL SECURITY NO. <u>Mrs. Florence Collins (mother)</u>				17. INFORMANT Address <u>Mrs. Florence Collins (mother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped in the water and drowned.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. a. m. <u>9.40 a. m. 7/7/57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severn River</u>		20f. (City or town) <u>Ferry Farm</u>		(County) <u>A.A.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/7/57</u>						DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>				22d. LOCATION (City, town, or county) <u>Princess Anne</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Berry, Jr.</u>						ADDRESS <u>Milford, Del.</u>					
24a. REC'D BY REGISTRAR <u>7/12/57</u>						24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. French</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 12 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07022

07065

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Riva			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tulip Rd.				d. STREET ADDRESS Tulip Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last Collins				4. DATE OF DEATH Month 7 Day 22 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 48 Days 22 Hours 19 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Collins				14. MOTHER'S MAIDEN NAME Mary L. Yoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Eileen S. Collins		Address Riva, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 19 57 , to JULY , 19 57 , that I last saw the deceased alive on JULY 22 , 19 57 , and that death occurred at 7:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED Aug 26 1957							
ACTUAL SIGNATURE E. L. ...		M.D. Aug 26 1957					
PHYSICIAN'S NAME (Type) E. L. ...		Aug 26 1957 - MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Talley Funeral Home - Catonsville, Md.				24a. REC'D BY REGISTRAR JUL 26 1957		24b. REGISTRAR'S SIGNATURE John J. French	

CERTIFICATE OF DEATH

THIRD

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE		MD		U.S.A.	
OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Carpenter		1234 E. Main St.		JUL 26 1957		BALTIMORE		MD		U.S.A.		Heart Disease		Natural	
DISEASE OR INJURY		DIAGNOSIS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS		OCCUPATIONAL HISTORY	
Myocardial Infarction		Coronary Artery Disease		Medication		Previous Illnesses		Family History of Heart Disease		Smoking History		Alcohol Consumption		Occupational Stress	
DATE OF EXAMINATION		BY WHOM EXAMINED		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL SEAL		FEE PAID		REMARKS		REMARKS	
JUL 26 1957		J. H. HARRIS		[Signature]		[Signature]		[Seal]		[Stamp]		[Text]		[Text]	

BUREAU V. S.

JUL 26 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07025

CERTIFICATE OF DEATH

Reg. Dist. No.

07023

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>		d. STREET ADDRESS <u>50 RIVER DRIVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY F DAW</u>		4. DATE OF DEATH Month Day Year <u>7-10-1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-79</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN REARDON</u>		14. MOTHER'S MAIDEN NAME <u>COWL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>GEORGE W. DAW</u>		Address <u>50 RIVER DRIVE BAY RIDGE MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cowman + thrombosis - uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420.1</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5/12/1957</u> to <u>7/10/1957</u> , that I last saw the deceased alive on <u>7/10/1957</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>7/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>17 Nnapolis</u> <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smt Olivet Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington</u> <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spencer J. Collins</u>		ADDRESS <u>3821-14th N.W.</u>	24a. REC'D BY REGISTRAR <u>DATE 7/12/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. French</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957 12

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07066

CERTIFICATE OF DEATH

070248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4yrs.23days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Loleta Middle Deaton Last Deaton				4. DATE OF DEATH Month 7 Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/9/89 ?	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 25 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Work		10b. KIND OF BUSINESS OR INDUSTRY Private homes	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Alexander Coker				14. MOTHER'S MAIDEN NAME Lizzie Hard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Long standing heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far advanced active Tuberculosis 002X							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 7/22 , 19 57 , to 7/25 , 19 57 , that I last saw the deceased alive on 7/25 , 19 57 , and that death occurred at 5:15pM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Hamilton M.D.				ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 7/25/57			
PHYSICIAN'S NAME (Type) John Hamilton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		22d. LOCATION (City, town, or county) (State) Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Baeton & Baeton Son Centreville				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE E. M. Joyce	

JUL 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

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1957 29 1957

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CERTIFICATE OF DEATH

07025

Reg. Dist. No.

07026

1. PLACE OF DEATH o. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 323 ADAMS ST.		d. STREET ADDRESS 323 ADAMS ST	
3. NAME OF DECEASED (Type or print) First Middle Last ELLA MAY DEBRICK		4. DATE OF DEATH Month - Day Year 7 5 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE L. KROH		14. MOTHER'S MAIDEN NAME MARY BAUGHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NRS SADIE E. HOLLAND #2	
17. INFORMANT NRS SADIE E. HOLLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic-Vascular Disease (b) 420.1 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 290.0 Pernicious Anemia		INTERVAL BETWEEN ONSET AND DEATH Insidious yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1946 to July 5, 1957 , that I last saw the deceased alive on June 30, 1957 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 31 Southgate Ave DATE SIGNED 7/6/57 ACTUAL SIGNATURE Maurice Klawans M.D. PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS Annapolis Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-8-57	22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	22d. LOCATION (City, town, or county) (State) Baltimore MD
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		24a. REC'D BY REGISTRAR 7/8/57	24b. REGISTRAR'S SIGNATURE J. D. Francis

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through from the reverse side.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with- page 3. This page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with- the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07067

CERTIFICATE OF DEATH

07026

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broadwater, Arnold. 29</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broadwater, Arnold. Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broadwater, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Clarence Doyle</u>				4. DATE OF DEATH Month Day Year <u>7 27 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27 1878</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Clarence Doyle</u>				14. MOTHER'S MAIDEN NAME <u>Leonore Griffith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Brother Arthur R. Doyle</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 to <u>present</u> , 19 that I last saw the deceased alive on <u>25 July</u> , 19 <u>57</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severus Park Md</u> DATE SIGNED <u>7-27-57</u>							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert R. HAHN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook/4c. 1517 St Paul St</u>				24. REC'D BY REGISTRAR <u>301957</u> 24b. REGISTRAR'S SIGNATURE <u>Ly. Adley</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07068

CERTIFICATE OF DEATH

Reg. Dist. No. 28

07027

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville, Maryland</u>		d. STREET ADDRESS <u>2033 McCulloh Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Duke</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-84</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosp. Orderly</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Duke</u>		14. MOTHER'S MAIDEN NAME <u>Edith Tabbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure, acute (Myocardial infarct)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CNS Lues and General Paresis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia, Pulmonary Tb., Arteriosclerosis, ininiton</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>57</u> , to <u>7-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>57</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>7-30-57</u>	
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-1-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow Calvert md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>P. E. Sewell</u>	
24a. REC'D BY REGISTRAR <u>July 31</u>		24b. REGISTRAR'S SIGNATURE <u>X M. Joyce</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07027

CERTIFICATE OF DEATH

Reg. Dist. No.

07028

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN 1b 31 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 1205 McKinley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Gertrude Last DUNLEAVY				4. DATE OF DEATH Month July Day 29 Year 19 57			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Feb 1889		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James John JUDGE				14. MOTHER'S MAIDEN NAME Mary Jennie GORMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT USNH Annapolis, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: ADENOCARCINOMA 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Approx. 9 Mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-29-57 , 19 57 , to 7-27 , 19 57 , that I last saw the deceased alive on 7-27 , 19 57 , and that death occurred at 1:45 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. W. MEYER JR.				ADDRESS (Street, city or town, state) U.S. Naval Hosp. Annapolis, Md. DATE SIGNED 7-29-57			
PHYSICIAN'S NAME (Type) F. W. MEYER JR. CDR MC USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 7/30/57 24b. REGISTRAR'S SIGNATURE J. P. Dunc...	

07029

07069

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Eckman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 28, 1903</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ft. Meade Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Eckman</u>				14. MOTHER'S MAIDEN NAME <u>Dora B. Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-22-2200</u>		17. INFORMANT <u>Warren F. Brown, Odenton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Colitis (Non-specific)</u> <u>541.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastrectomy (Sub-total)</u> DUE TO (c) <u>Duodenal ulcer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>5 mo</u> <u>5 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>571.1</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 29</u> , 1957, to <u>July 2</u> , 1957, that I last saw the deceased alive on <u>July 2</u> , 1957, and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Milton Luthien</u>				ADDRESS (Street, city or town, state) <u>106 W. Maple Rd. Luthien</u>			
PHYSICIAN'S NAME (Type) <u>M.D.</u>				DATE SIGNED <u>July 7/4/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Epis. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mara Keshy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7000

See last page

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Race		7. Religion		8. Marital status		9. Occupation		10. Cause of death		11. Date of death		12. Place of death		13. Signature of physician		14. Signature of registrar		15. Signature of informant	

C7028

CERTIFICATE OF DEATH

07030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Near Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>Box 608 Revel Highway</u>			
3. NAME OF DECEASED (Type or print) <u>Grover</u> First <u>Emrick</u> Middle <u>Emrick</u> Last				4. DATE OF DEATH <u>July</u> Month <u>28</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-1885</u>	
9. AGE (In years, lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>"UNK"</u>				14. MOTHER'S MAIDEN NAME <u>"UNK"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>JAMES EMRICK</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes m.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15/57</u> , 19 <u>57</u> , to <u>7/28/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/28</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.				ADDRESS (Street, city or town, state) <u>630 College Ave</u> DATE SIGNED <u>7/29/57</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-31-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Date of registration		14. Registrar's office	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07031

07070

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>9 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> X 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>Box 278 Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Gandy</u> Last <u>Laura</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2rd.</u> Year <u>19 57</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/86</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cephus</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Pack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-3943</u>		17. INFORMANT Address <u>Mrs. D. Matthews (niece) Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Diseases.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/3/57</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law - 802 Madison Avenue</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH-BALTIMORE-16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

1957 8 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07032

07071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>				c. LENGTH OF STAY IN 1b <u>30 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>416 E. SEWARD AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN HARRY GARREIS</u>				4. DATE OF DEATH Month Day Year <u>JULY 30 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 6, 1899</u>	
9. AGE (In years last birthday) yrs. <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MICHAEL A. GARREIS</u>				14. MOTHER'S MAIDEN NAME <u>MARY BIRMINGHAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES C.W.I.</u>		16. SOCIAL SECURITY NO. <u>215-07-7690</u>		17. INFORMANT Address <u>MRS. HELEN GARREIS 416 E. SEWARD AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Oligoscleroma</u> <u>198X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 30, 1957</u> , to <u>July 30, 1957</u> , that I last saw the deceased alive on <u>July 30, 1957</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Herbert Mueller Jr</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4700 Pennington Ave. Balto 26, Md. 31 July 1957</u>			
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>				<u>4700 PENNINGTON AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE HWY AAC, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Rowe</u>				ADDRESS <u>4001 RITCHIE HWY</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John M. Minton</u>			

07029

CERTIFICATE OF DEATH

Reg. Dist. No. "L 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>20 East Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>B</u> Last <u>GATES</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Upton Shank</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis c. Post. Septal Defect</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vasc. Disease</u> DUE TO (c) <u>yes.</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus .260X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/29</u> , 19 <u>57</u> , to <u>July 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Southgate Rd Annapolis, Md</u> DATE SIGNED <u>7/8/57</u> ACTUAL SIGNATURE <u>Maurice F. Klawns</u> M.D. PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thm. J. Lunday</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		MARRIAGE <i>Married</i>	
AGE <i>45</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>Jan 15 1910</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>Jul 8 1957</i>		PLACE OF DEATH <i>Home</i>	
TIME OF DEATH <i>10:30 AM</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CORONER <i>John Doe</i>	
SIGNATURE OF DEATH REGISTRAR <i>John Doe</i>		SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
SIGNATURE OF STATE DEPARTMENT OF HEALTH <i>John Doe</i>		SIGNATURE OF BALTIMORE CITY CLERK <i>John Doe</i>	

RECEIVED
JUL 9 1957
BUREAU V. S.

07972

CERTIFICATE OF DEATH

07034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>855 W. Franklin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>Gilliam</u> Last <u>Gilliam</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/00</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook - Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Archie Gillen</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Crownsville State Hospital</u> Address <u>Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute recurrent myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> <u>260x</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>57</u> , to <u>7/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>57</u> , and that death occurred at <u>3:10 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Corwell Newton</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>	
DATE SIGNED <u>7/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Corwell Newton, M. D.</u>			
22a. BURIAL CREMATION, etc. (Specify)	22b. DATE THEREOF <u>7/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Long Island Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Farmingdale New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Steele P. Hicks</u> ADDRESS <u>43 Northwest St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/26/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>x.m. Goya</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

07035

C7030

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>45 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gustav</u> Middle <u>(n)</u> Last <u>GRAUBAUM</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5 June 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUC USN RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N. MUC RET</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Carl GRAUBAUM</u>				14. MOTHER'S MAIDEN NAME <u>JOHAN QUENTZLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WWL</u>		17. INFORMANT <u>U.S.N. Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Common duct obstruction</u> DUE TO (c) <u>Diabetes Mellitis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 May, 1957</u> to <u>9 July, 1957</u> , that I last saw the deceased alive on <u>9 July, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. J. Miller</u>				ADDRESS (Street, city or town, state) <u>U.S.N. Hospital, Annapolis, MD</u>			
PHYSICIAN'S NAME (Type) <u>M. J. MILLER, LT, MC, USN</u>				DATE SIGNED <u>10 July 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>7/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. French</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
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88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

BUREAU V. 3

JUL 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 07036										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS Parker & Bowie Ave.					
3. NAME OF DECEASED (Type or print) First Lillian Middle Green Last Green					4. DATE OF DEATH Month July Day 20 Year 19 57					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-1927		9. AGE (In years last birthday) 30 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Home			10b. KIND OF BUSINESS OR INDUSTRY C. A. Co. Md.			11. BIRTHPLACE (State or foreign country) U. S. A.			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Parker					14. MOTHER'S MAIDEN NAME Estelle Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. —		17. INFORMANT Mary E. Simms Anna. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lethal midline granuloma 587.2 DUE TO Fibrosis and calcification of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Organizing bronchopneumonia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE R. S. Fisher					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8-3-57		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Md.			
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Anna. Md.					ADDRESS		24a. REC'D BY REGISTRAR AUG 2 1957		24b. REGISTRAR'S SIGNATURE Thos. French	

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 2 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07037

Reg. Dist. No. 24

07073

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b <u>8 y.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Luna Lane, Round Bay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Yeager Hambleton</u>				4. DATE OF DEATH Month Day Year <u>July 3rd. 19 57</u>													
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/76</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News paper Carttonist, Artist and Illustrator, Mount Savage, Md.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mount Savage, Md.</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Richard Emory Hambleton</u>						14. MOTHER'S MAIDEN NAME <u>Ella Yeager</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-07-7147</u>				17. INFORMANT Address <u>Mrs. Alice B. Hambleton, (wife) Round Bay, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes.</u>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/3/57</u>						DATE SIGNED											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. T. Tucker & Sons, Balto. Md.</u>						24a. REC'D BY REGISTRAR <u>7/3/57</u>						24b. REGISTRAR'S SIGNATURE <u>L. J. Sealy</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

JUL 8 1957

RECEIVED

(7032

CERTIFICATE OF DEATH

07038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Monument St.</u>		d. STREET ADDRESS <u>25 Monument St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Months <u>6</u> Days <u>28</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bot. Family</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Edw. Samuels</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Lee</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. <u>778</u>		17. INFORMANT <u>Flourence Murray-Anna, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Ext. 30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-18-57</u> , 19 <u> </u> , to <u>7-28-57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>7-13-57</u> , 19 <u> </u> , and that death occurred at <u>1:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>7-28-57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Lee, Jr. - Anna, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURMAN V. S.

JUL 30 1957

RECEIVED

C7033

CERTIFICATE OF DEATH

070321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>226 Hindell Ave</u>		d. STREET ADDRESS <u>226 Hindell Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Hawkins</u> Middle <u>Hawkins</u> Last		4. DATE OF DEATH <u>7</u> Month <u>16</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathaniel Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Ann Spriggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, state year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Marion Hawkins Ann Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-14-57</u> 19, to <u>7-16-57</u> 19, that I last saw the deceased alive on <u>7-15-57</u> 19, and that death occurred at <u>6:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.		DATE SIGNED <u>7-16-57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
<u>Burial</u>	<u>7-19-57</u>	<u>Mt. Tabor</u>	<u>Chesterfield, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. L. Anna, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>7/29/57</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name (Printed) _____
 Sex _____
 Date of Birth _____
 Place of Birth _____
 Date of Death _____
 Cause of Death _____
 Signature of Physician _____
 Signature of Registrar _____
 Date of Registration _____
 Place of Registration _____

BUREAU V. 1

JUL 30 1957

RECEIVED

Received 7-13-57
 J. H. [illegible]
 [illegible]

[illegible]
 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07074

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHERWOOD FOREST		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 5707 Chinquapin Pkwy.	
3. NAME OF DECEASED (Type or print) First HOLMES Middle S. Last HEIMERT		4. DATE OF DEATH Month JULY Day 7 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 19, 1910
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres.		10b. KIND OF BUSINESS OR INDUSTRY Creamery Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert Heimert, Sr.		14. MOTHER'S MAIDEN NAME Katherine Holmes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-5925	
17. INFORMANT Mr. Albert Heimert, Jr.		Address -724 Dunkirk Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850x DROWNING DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHEST DEFORMITY - CONGENITAL KYPHOSIS, PIGEON BREAST			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL FROM BOAT, ATTEMPTED SWIM ASHORE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 7:15 7/7 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ANNAPOLIS		20f. (City or town) (County) (State) ANNE ARUNDEL MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Edward S. Beck		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balt.		24a. REC'D BY REGISTRAR JUL 10	
ADDRESS		24b. REGISTRAR'S SIGNATURE A. J. Dealy	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07075

CERTIFICATE OF DEATH

07041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3yrs.3mos.3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS None listed			
3. NAME OF DECEASED (Type or print) First Herman Middle Holland Last Holland				4. DATE OF DEATH Month 7 Day 15 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not listed	
9. AGE (In years last birthday) 68?		IF UNDER 1 YEAR Months 7 Days 15 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal pneumonia DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Syphilitic aortitis, cellulitis of right arm							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 493X				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from 7/1 , 19 57 , to 7/15 , 19 57 , that I last saw the deceased alive on 7/15 , 19 57 , and that death occurred at 12:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 7/16/57							
ACTUAL SIGNATURE Conwell Newton M.D.				PHYSICIAN'S NAME (Type) Conwell Newton, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/18/57		Hopkins Chapel, Howard County, Md.		Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Snouden				24. REG'D BY REGISTRAR 191957			
ADDRESS Rockville, Md.				25. REGISTRAR'S SIGNATURE A. M. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWEE		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWEE	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWEE		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWEE		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWEE	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWEE		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWEE		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWEE	
40. SIGNATURE OF INTERVIEWER		41. SIGNATURE OF INTERVIEWEE		42. SIGNATURE OF INTERVIEWER	
43. SIGNATURE OF INTERVIEWEE		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWEE	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWEE		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWEE		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWEE	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWEE		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWEE		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWEE	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWEE		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWEE		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWEE	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWEE		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWEE		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWEE	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWEE		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWEE		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWEE	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWEE		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWEE		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWEE	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWEE		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWEE		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWEE	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWEE		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWEE		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWEE	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWEE		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWEE		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWEE	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	

RECEIVED
JUL 10 1957
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5 FilmG218 7-30-57 et

Reg. Dist. No. 22

07076

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. LENGTH OF STAY IN 1b 28y.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 297 X				d. STREET ADDRESS 1 Same			
3. NAME OF DECEASED (Type or print) First Middle Last Rosa E. Hood				4. DATE OF DEATH Month Day Year July 20 1957			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/03		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Odenton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alphonse Knight				14. MOTHER'S MAIDEN NAME Nanie Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Leslie Hood (husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Puncture wound of the heart self inflicted with 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) a 12 gauge double barrel shot gun. DUE TO (c) _____ Sudden						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot herself through the heart with a 12 gauge shot gun.					
20c. TIME OF INJURY Month, Day, Year 9.15 a.m. 7/20/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Attic at home.		20f. (City or town) (County) (State) Odenton A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 23/57		22c. NAME OF CEMETERY OR CREMATORY Nichols-Bethel Ch. Cem. Odenton, Maryland	
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.				24a. REC'D BY REGISTRAR Jul 25 1957		24b. REGISTRAR'S SIGNATURE <i>Clara Shalups</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Singleton</i>				24. CHIEF MEDICAL EXAMINER Gustave H. Faubert, M.D.			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Gustave H. Faubert, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

July 21st. 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to fading and bleed-through from the reverse side.

BUREAU V. S.

JUL 25 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director may detach page 3 for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG219 8-28-57 et

07977

CERTIFICATE OF DEATH

070438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville				c. LENGTH OF STAY IN 1b 6/6/54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sann Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harriett Ann Hopkins				4. DATE OF DEATH Month Day Year July 26th. 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/91		9. AGE (In years lost birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (invalid all her life)				10b. KIND OF BUSINESS OR INDUSTRY Invalid all her life		11. BIRTHPLACE (State or foreign country) Crisfield, Md.	
13. FATHER'S NAME William D. Hopkins				14. MOTHER'S MAIDEN NAME Sarah Jane Revell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Sann's Nursing Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio vascular diseases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute cystitis DUE TO (c) Invalid due to bony discrepancy ever since the (age of 3 years.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Retardation							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/10/54 , 19____, to 7/26/57 , 19____, that I last saw the deceased alive on 7/26/57 , 19____, and that death occurred at 2.30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 7/27/57							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-28-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Sayler Sons				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 7/30/57	
24b. REGISTRAR'S SIGNATURE J. M. Jones				24c. REGISTRAR'S SIGNATURE J. M. Jones			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA	
PREVIOUS ILLNESS		TREATMENT		HOSPITAL		PHYSICIAN		NURSE		CORONER		BURIAL		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF BURIAL		SIGNATURE OF REMARKS		SIGNATURE OF PREVIOUS ILLNESS		SIGNATURE OF TREATMENT		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE	

BUREAU V. 1

JUL 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 Kimberly Court		d. STREET ADDRESS 7 Kimberly Court	
3. NAME OF DECEASED (Type or print) First MARJORIE Middle JEAN Last HOWELL		4. DATE OF DEATH Month July Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16-1920
9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) TULSA OKLAHOMA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Donaldson C. Robertson		14. MOTHER'S MAIDEN NAME Maudie Bates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Jack M. Howell Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute barbiturate poisoning 970.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute alcoholism DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested overdose of barbiturates	
20c. TIME OF INJURY Month, Day, Year 1:30 p.m. 7 24 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Severna Park (County) Anne A. undel Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-57	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) Glen Burnie Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Cannapolis Md		24a. REC'D BY REGISTRAR 7/26/57	
		24b. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 29 1957

RECEIVED

Remell H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07079

CERTIFICATE OF DEATH

07045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 62 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 2625 Boone Street	
3. NAME OF DECEASED (Type or print) First Ruth Middle Isabella Last Jackson		4. DATE OF DEATH Month 7 Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/12
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Housework		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Carter		14. MOTHER'S MAIDEN NAME Mattie Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the bladder DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/29 , 19 57 , to 7/17 , 19 57 , that I last saw the deceased alive on 7/16 , 19 57 , and that death occurred at 1:20a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 7/17/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/19/57	
22c. NAME OF CEMETERY OR CREMATORY mt. Calvary		22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rayne Sanders Address 215 E. Preston St. Balt & Md.		24a. REC'D BY REGISTRAR DATE 7/18/57	
24b. REGISTRAR'S SIGNATURE J. M. Joyce			

BUREAU V. S.

1957 87 701

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07046 *24*

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07080

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Margate Drive</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> <u>X2</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Joseph M. James</u> First Middle Last				4. DATE OF DEATH <u>July 21st.</u> 19 <u>57</u> Month Day Year							
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/84</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Gas & Electric Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montreal, Canada.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph M. James</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hughs</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, I World War.</u>				16. SOCIAL SECURITY NO. <u>212 05 4731</u>		17. INFORMANT <u>Mrs. Catherine James (wife)</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Dislocation of 6th Cervical</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vertebra</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7/21/57</u> 19 <u>PM.</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Glen Burnie Anne Arundel Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>William Upchurch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7-21-57</u>			
EXAMINER'S NAME (Type) _____				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. King</u>				ADDRESS <u>Glen Burnie, Md.</u>		24. REC'D BY REGISTRAR <u>JUL 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Schallap</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint handwriting.

BUREAU V. 5

JUL 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07047

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY A.A. Co		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) Baltimore		TOWN 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home				STREET ADDRESS 2566 Hollins Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Hesther A. Johns				4. DATE OF DEATH (Month) (Day) (Year) July 4 1957			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH about 1880	9. AGE last birthday 77 ? yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME John Dove				14. MOTHER'S MAIDEN NAME Julia (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs. Cole, 207 Register Ave, Baltimore			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) CEREBRAL THROMBOSIS						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
ANTECEDENT CAUSE(S) DUE TO (B) CEREBRAL ARTERIOSCLEROSIS						5 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) GENERALIZED ARTERIOSCLEROSIS						UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 4-50-0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from DEC 1954, to 4 July 1957, that I last saw the deceased alive on 3 July 1957, and that death occurred at 2 P.M. from the causes and on the date stated above.							
SIGNATURE Edward A. Beck				M.D. 41 Southgate Ave ANNAPOLIS		DATE SIGNED 7/5/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-6-57		NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		LOCATION (City, town, or county) Baltimore, Md.	
24. REC'D BY REGISTRAR JUL 9 1957		REGISTRAR'S SIGNATURE Wm. J. French		25. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Small Print Text

1. PLACE OF DEATH

MARYLAND

2

IN MEDICAL INVESTIGATION

BUREAU V. S.

JUL 9 1957

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS A STATISTICAL REPORT REQUIRED BY THE FEDERAL GOVERNMENT AND THE STATE OF MARYLAND. IT IS TO BE FILLED OUT BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE PERSON IN CHARGE OF THE DECEASED IF NO PHYSICIAN IS AVAILABLE. IT IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7)35

CERTIFICATE OF DEATH

07048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>88 Charles St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nina</u> Middle <u>S.</u> Last <u>Joyner</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John N. Savage</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Samuel Sabel</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS GENERALIZED</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>3 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 July</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>4150 Southgate Ave</u> DATE SIGNED <u>7/3/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D.</u>		<u>ANNAPOLIS MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>	22b. DATE THEREOF <u>7-6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wilmington N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>7/5/57</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

BUREAU V. 3

RECEIVED

Item 20 Film 218 7-26-57 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07049**

67036

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb Pines on Severn		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Pines on Severn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 203 Shiley Street		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Glen Middle Keatley Last Kelly		4. DATE OF DEATH Month July Day 1 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1915
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Oil Burner	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Keatley		14. MOTHER'S MAIDEN NAME Lula Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Opal Keatley		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 892.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) --- (a), stating the underlying cause lost, (c) --- DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
INTERVAL BETWEEN ONSET AND DEATH ---			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally poisoned by carbon monoxide	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7/1/57 19 p. m. ---		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) building		20f. (City or town) (County) (State) Annapolis Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 7/1/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1957	
22c. NAME OF CEMETERY OR CREMATORY Hallcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Taylor & Sons		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR 7/3/57		24b. REGISTRAR'S SIGNATURE J. D. Dunch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. 1

JUL 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07050

07081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park 25</u>				c. LENGTH OF STAY IN 1b <u>21 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#113 5th. ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>KITTEL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1904</u>	
9. AGE (In years lost birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wheeling, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel E. McCarty</u>		14. MOTHER'S MAIDEN NAME <u>Birdie Bowman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or dates of service: <u>--</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Mary J. Wilson</u>		Address <u>416 Mariban Court Balto., 25, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary with</u> <u>175x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>widespread metastases</u> DUE TO (c) <u>1 yr -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6, 1957</u> , to <u>July 22, 1957</u> , that I lost sowing the deceased olive on <u>7/22</u> , 19 <u>57</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5010 A Ritchie Highway Balto 25, Md.</u> <u>July 24/57</u>							
ACTUAL SIGNATURE <u>Morton M. Krieger</u> M.D.		PHYSICIAN'S NAME (Type) <u>MORTON M. KRIEGER M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jul 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John Wilson</u>		DATE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUL 29 1957

RECEIVED

07082

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Heights				c. LENGTH OF STAY IN lb XO Brooklyn Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Wood St.				d. STREET ADDRESS 505 Wood St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAE Last KLAGES				4. DATE OF DEATH Month July Day 6 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hugh H. Klages				14. MOTHER'S MAIDEN NAME Almira V. Fairall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Myrtle A. Hickcox - 505 Wood St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.P.C. - lungs - Asbestos 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cardio Vascular disease with DUE TO dilated heart. myocardial hypertrophy (c) myocardial hypertrophy						INTERVAL BETWEEN ONSET AND DEATH 3 mo 2 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28 , 19 57 , to July 6 , 19 57 , that I last saw the deceased alive on July 6 , 19 57 , and that death occurred at 2:09 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. E. Wilson M.D.				ADDRESS (Street, city or town, state) 6 East Biddle St. Baltimore, Md.			
DATE SIGNED July 9, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner & Sons - Balto 17 Ind.				24a. REC'D BY REGISTRAR DATE 7/10/57		24b. REGISTRAR'S SIGNATURE Ada Whitson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

24

1957

RECEIVED

07083 **CERTIFICATE OF DEATH**

Item 7 FilmG217 7-10-57 et

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>13 Heath Ave. Linthicum, Md.</u>				STREET ADDRESS <u>13 Heath Avenue</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>ERNA</u> (First) (Middle) <u>KRESS</u> (Last)				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>5</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 7, 1904</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hanover, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fritz Dryer</u>				14. MOTHER'S MAIDEN NAME <u>Francisco</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Carl F. Kress 13 Heath Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>Carcinomatosis General</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of the</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>pancreas</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from June 28, 1957, to July 5, 1957, that I last saw the deceased alive on June 28, 1957, and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Joseph T. Cole</u> M.D.				DATE SIGNED <u>7-5-1957</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-9-57</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Ave.</u>			
DATE <u>JUL 8 '57</u>							

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

07-83

1. DEATH CERTIFICATE NUMBER - 1234567

2. PLACE OF DEATH

3. MARRIAGE

4. DATE OF BIRTH

5. SEX

6. RACE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF NOTARY

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF DEPUTY SHERIFF

23. SIGNATURE OF CONSTABLE

24. SIGNATURE OF JAILER

25. SIGNATURE OF WARDEN

26. SIGNATURE OF CHIEF OF POLICE

27. SIGNATURE OF DETECTIVE

28. SIGNATURE OF INSPECTOR

29. SIGNATURE OF SUPERVISOR

30. SIGNATURE OF AGENT

31. SIGNATURE OF CLERK

32. SIGNATURE OF RECEPTIONIST

33. SIGNATURE OF MAIL ROOM

34. SIGNATURE OF TELEPHONE ROOM

35. SIGNATURE OF JANITOR

36. SIGNATURE OF GARDENER

37. SIGNATURE OF COOK

38. SIGNATURE OF BUTLER

39. SIGNATURE OF HOUSEKEEPER

40. SIGNATURE OF MAINTENANCE

41. SIGNATURE OF SECURITY

42. SIGNATURE OF IT

43. SIGNATURE OF HR

44. SIGNATURE OF FINANCE

45. SIGNATURE OF LEGAL

46. SIGNATURE OF COMPLIANCE

47. SIGNATURE OF QUALITY

48. SIGNATURE OF OPERATIONS

49. SIGNATURE OF LOGISTICS

50. SIGNATURE OF SUPPLY

51. SIGNATURE OF PROCUREMENT

52. SIGNATURE OF CONTRACT

53. SIGNATURE OF VENDOR

54. SIGNATURE OF MANUFACTURER

55. SIGNATURE OF DISTRIBUTOR

56. SIGNATURE OF RETAILER

57. SIGNATURE OF CONSUMER

58. SIGNATURE OF END USER

59. SIGNATURE OF CUSTOMER

60. SIGNATURE OF CLIENT

61. SIGNATURE OF PATIENT

62. SIGNATURE OF VISITOR

63. SIGNATURE OF STAFF

64. SIGNATURE OF VOLUNTEER

65. SIGNATURE OF DONOR

66. SIGNATURE OF RECIPIENT

67. SIGNATURE OF BENEVOLENT

68. SIGNATURE OF CHARITABLE

69. SIGNATURE OF GRACIOUS

70. SIGNATURE OF BENEVOLENT

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07053

07084 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ferndale</u>		LENGTH OF STAY (In this place) <u>33 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale (Glen Burnie)</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u># 9 N. Baltimore Ave</u>				STREET ADDRESS (If rural give location) <u>29-14- Balto. Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Herbert Boyarsk Landersteger</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>56</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 27 '31</u>	9. AGE last birthday <u>26</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Z.</u>				14. MOTHER'S MAIDEN NAME <u>(48394) Laura J. Frey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-45397</u>		17. INFORMANT & ADDRESS <u>Landersteger (daughter)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cardio Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>				3 yrs. -			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>450-2</u>		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1942</u> to <u>7/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/26</u> , 19 <u>57</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball Jr.</u>				M.D. <u>Linthicum</u>		DATE SIGNED <u>7/26/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 29, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>MT. Olivet</u>		LOCATION (City, town, or county) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR DATE <u>AUG 2 1957</u>		REGISTRAR'S SIGNATURE <u>L. J. Seabury</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. R. King</u>		ADDRESS <u>Glen Burnie, Md.</u>	

1908; CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

When filed, file

1. NAME OF DECEASED (PRINTED OR WRITTEN)

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

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BUREAU V. S.

AUG 2 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07085

Reg. Dist. No.

AUG-31 07054

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE MD		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BRISTOL		LENGTH OF STAY (in this place) 15 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BRISTOL			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (First) (Middle) (Last) Gilbert Leroy Lane				4. DATE OF DEATH (Month) (Day) (Year) 7 30 19 57			
5. SEX M	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH MAY 11 1911	9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OWINGS, CALVERT CO MD		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME WILLIAM LANE				14. MOTHER'S MAIDEN NAME ELSIE WATKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS ALICE CURTIS		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
322.0 IMMEDIATE CAUSE (A) acute alcoholism						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DUE TO							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from initially 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 2:45 PM , from the causes and on the date stated above.							
SIGNATURE Emily H. Wilm acting corner				ADDRESS (Street, city, town, state) Lothian, Md		DATE SIGNED 8-1-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF AUG 2, 1957		NAME OF CEMETERY OR CREMATORY Halls		LOCATION (City, town, or county) Halls Creek Md.	
24. REC'D BY REGISTRAR 8/5/57		REGISTRAR'S SIGNATURE Francis Bernard Hardesty		25. FUNERAL DIRECTOR'S SIGNATURE Francis Bernard Hardesty		ADDRESS	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

(7037)

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 195 Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AGNES LEE LEWIS Middle Last				4. DATE OF DEATH Month July Day 9 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Mayo, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Lee				14. MOTHER'S MAIDEN NAME Mary Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-0160		17. INFORMANT Address Miss Carrie Virginia Lee- Sister- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery Thrombosis 332X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X Cerebra							INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to July , 19 57 , that I last saw the deceased alive on July 9 , 19 57 , and that death occurred at 11:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Hedeman M.D. July 9, 1957							
ACTUAL SIGNATURE John H. Hedeman				PHYSICIAN'S NAME (Type) John Hedeman MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemet	
22d. LOCATION (City, town, or county) Mayo, Maryland				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 7/12/57	
24b. REGISTRAR'S SIGNATURE Dr. Wm. P. Church							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G219 8-14-57 et

CERTIFICATE OF DEATH

07056

Reg. Dist. No.

07086

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. c. LENGTH OF STAY IN 1b 18 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 444. Pri. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1634.2 N. Brentwood d. STREET ADDRESS 4017 Webster Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALFRED Middle LEWIS Last LEWIS		4. DATE OF DEATH Month July Day 12 Year 1957	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH 4-8-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Lewis		14. MOTHER'S MAIDEN NAME Sarah Holmes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital's record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 30, 1956 to July, 12, 1957 , that I last saw the deceased alive on July, 12, 1957 , and that death occurred at 11:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		DATE SIGNED Crownsville State Hospital	
PHYSICIAN'S NAME (Type) LUDWIG BENEDICT		CROWNSVILLE, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7-17-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) 4611-Benning Rd. SE. Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE William Spangler		24. REC'D BY REGISTRAR 161557	
ADDRESS 524-8-St. N. Wash. D.C.		24b. REGISTRAR'S SIGNATURE A. M. Joyce	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

JUL 16 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

Reg. Dist. No.

07987

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> c. LENGTH OF STAY IN 1b <u>25 y.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>307 W. Greenwood Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hezekiah Linthicum</u>				4. DATE OF DEATH Month Day Year <u>July 20th. 19 57</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/28/92</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A. Martinole</u>		11. BIRTHPLACE (State or foreign country) <u>Linthicum, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hezekiah Linthicum</u>				14. MOTHER'S MAIDEN NAME <u>Livinia Hines</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 24 986</u>		17. INFORMANT Address <u>Mrs. Ellie M. Linthicum (wife)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (c), stating the underlying cause last, DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mid-thigh amputations of both legs: January 1952- May 1952</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> ?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>450.1</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard K. [Signature]</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU 15

JUL 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07058

07038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annopolis Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>				d. STREET ADDRESS <u>SPA Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Marie Channing Linthicum</u>				4. DATE OF DEATH <u>7-15-1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1889</u>	
9. AGE (In years last birthday) <u>68</u> Yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>			
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Theodore H. Linthicum</u>				14. MOTHER'S MAIDEN NAME <u>George Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>na</u>			
17. INFORMANT <u>John B Wells</u>				Address <u>Taneyline City</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> 330X DUE TO (c) <u>Gen. Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 mo.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>1957</u> , 19____, that I last saw the deceased alive on <u>7-14-57</u> , 19____, and that death occurred at <u>10:4</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md</u>			
DATE SIGNED <u>7-15-57</u>							
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>7/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>10-57</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07059	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills c. LENGTH OF STAY IN 1b -1-y. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S.A. Naval Academy Dairy					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2025 East Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					3V01-4	
3. NAME OF DECEASED (Type or print) First Middle Last Linda M Loudermilk					4. DATE OF DEATH Month Day Year July 5th. 19 57						
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/45		9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pupil			10b. KIND OF BUSINESS OR INDUSTRY At School		11. BIRTHPLACE (State or foreign country) Isabelle, Tenn.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hansel Loudermilk					14. MOTHER'S MAIDEN NAME Bertha Harrison						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. H. Loudermilk			Address 2025 E Baltimore St				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound of Head 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally shot with shotgun								
20c. TIME OF INJURY Month, Day, Year Hour 9:20 7/5/57 19 P. M.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tenant's house		20f. (City or town) Gambrills		(County) Anne Arundel		(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE William Updell EXAMINER'S NAME (Type) William Updell					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 7-6-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel Cemetery			22d. LOCATION (City, town, or county) O'Donnel Street Md.				
23. FUNERAL DIRECTOR'S SIGNATURE D. Appel Bros. ADDRESS 1800 E Lombard St.						24a. REC'D BY REGISTRAR JUL 9 1957		24b. REGISTRAR'S SIGNATURE H. M. Joyce			

BUREAU V. S.

JUL 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

07039

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>149 Monticello Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sallie O. Lyons</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1868</u>
9. AGE (In years, months, days) <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Leatherbury</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Olivia Lamb</u>		Address <u># 2</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April, 1954</u> to <u>12 July, 1957</u> , that I last saw the deceased alive on <u>12 July, 1957</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>4150 50th Gate Ave</u> DATE SIGNED <u>7/15/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD</u>		<u>ANNAPOLIS</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>7/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

BUREAU V. S.

JUL 17 1957

RECEIVED

07040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Everistus P. McGuire</u>				4. DATE OF DEATH <u>7-8-1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 26th 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service man</u>		11. BIRTHPLACE (State or foreign country) <u>Orange N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul McGuire</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>"</u>		17. INFORMANT <u>Laurence McGuire</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> 14 wks 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Valvular Heart Disease</u> 40 yrs DUE TO (c) <u>Rheumatic Fever</u> 40 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/6, 1957</u> to <u>7/8, 1957</u> , that I last saw the deceased alive on <u>7/7, 1957</u> , and that death occurred at <u>7:54 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>				ADDRESS (Street, city or town, state) <u>41 Southgate Ave, Annapolis</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>				DATE SIGNED <u>7/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>				<u>Orange N.J.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis MD</u>		24a. REC'D BY REGISTRAR DATE <u>7/9/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar's name and address.

BUREAU V. G.

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07089

CERTIFICATE OF DEATH

07062

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade c. LENGTH OF STAY IN 1b 1 hr 36 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 45 A Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle LEE Last MCVICKER		4. DATE OF DEATH Month July Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1957
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 36
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Nathan McVicker		14. MOTHER'S MAIDEN NAME Lois Virginia White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Naomi McVickers		Address Annapolis Junction, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 Respiratory Failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hr 36 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 July 1957 to 16 July 1957 , that I last saw the deceased alive on 16 July 1957 , and that death occurred at 5:03 A.M. from the causes and on the date stated above. 205 A ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Arnold Fiascone M.D. W. L. Saylor 16 July 1957 PHYSICIAN'S NAME (Type) ARNOLD FIASCONE, CAPT, MC, USAH, Ft. G. G. Meade, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18-57	
22c. NAME OF CEMETERY OR CREMATORY U.S. National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dewitt Donaldson ADDRESS Laurel, Maryland		24a. REC'D BY REGISTRAR W. L. Saylor DATE 16 Jul 57	
24b. REGISTRAR'S SIGNATURE W. L. Saylor		24c. REGISTRAR'S SIGNATURE W. L. Saylor	

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BUREAU V. S.

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07063

Reg. Dist. No.

07090

1. PLACE OF DEATH a. COUNTY AnneArundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crowsville				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crowsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Otto Middle Merriman Last Merriman				4. DATE OF DEATH Month 7 Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address State Hospital Crowsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 463x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis in extremities DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration, hypoxemia							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 6/22/57 , to 7/1/57 , that I last saw the deceased alive on 7/1/57 , and that death occurred at 9:00a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Conwell Newton				ADDRESS (Street, city or town, state) Crowsville, Md.		DATE SIGNED 7/1/57	
PHYSICIAN'S NAME (Type) Conwell Newton							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-3-57		22c. NAME OF CEMETERY OR CREMATORY Not given		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Keese ADDRESS 2200 E. 1st St. Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 5 1957		24b. REGISTRAR'S SIGNATURE A. M. Jones	

BUREAU V. S.

JUL 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07064

07091

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Mitter</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unk. July 4, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk.</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>unk.</u>				14. MOTHER'S MAIDEN NAME <u>unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital Records</u>				Address <u>Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Syphilitic Meningo-encephalitis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome asso. with CNS Syphilis, Meningoencephalitis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7-16-</u> , 19 <u>57</u> , to <u>7-30-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-30-</u> , 19 <u>57</u> , and that death occurred on <u>12:50</u> a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>7-30-57</u>							
ACTUAL SIGNATURE <u>Conwell Newton</u>				M.D. <u>Crownsville, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8-5-1957</u>		<u>MT. A4B4RN</u>		<u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herzog O. Dyett</u>				24a. REC'D BY REGISTRAR <u>916 penno</u>			
24b. REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>				DATE <u>1957</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

2 1957

WANDA TM 501-0-8 24119

WM 395 MIT-42

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07041

CERTIFICATE OF DEATH

07065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parole Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospt.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Virginia</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Eastport Md</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Eastport Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John A. Carr</u>				14. MOTHER'S MAIDEN NAME <u>Irene King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) [If yes, give war or dates of service] <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Harvey F. Myers</u>				Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X</u> <u>Metastatic carcinoma of cervix</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>57</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hederman</u>				M.D. <u>68 Franklin St.</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>				DATE SIGNED <u>7/15/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Parole Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>7/16/57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

JUL 17 1957

BUREAU A.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07066

07992

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quanton R.F.D. c. LENGTH OF STAY IN 1b 6 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Patuxant Road				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Harry Neary				4. DATE OF DEATH Month July Day 5th. Year 19 57											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15, 1875		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman (Ret)				10b. KIND OF BUSINESS OR INDUSTRY Pa. Rail Road		11. BIRTHPLACE (State or foreign country) Anne Arundel Co.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown) Neary						14. MOTHER'S MAIDEN NAME Raechael Conway									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Address Mrs. Blanche Fisher, Same As #2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH Sudden															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF July 8/57		22c. NAME OF CEMETERY OR CREMATORY Patuxant Ch. Cemetery				22d. LOCATION (City, town, or county) Patuxant, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. D. Livingston						ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE 7/13/57		24b. REGISTRAR'S SIGNATURE Clara Neelup					

DATE SIGNED

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

7/8/57

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES EARL RAY		MALE		35		APRIL 4, 1968	
PLACE OF DEATH		CITY		STATE		COUNTY	
MEMPHIS		MEMPHIS		MISSISSIPPI		SHELBY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		ALCOHOL	
HEART DISEASE		SUICIDE		NEGATIVE		NEGATIVE	
FINDINGS		TESTS		TREATMENT		HISTORY	
CORONARY AORTA		X-RAY		SUPPORTIVE		NONE	
MURDER		NORMAL		NONE		NONE	
FINGERPRINTS		LABORATORY		PATHOLOGICAL		ANTHROPOLOGY	
MATCH		CHEMISTRY		ANATOMY		PHYSIOLOGY	
YES		NONE		NORMAL		NORMAL	
SIGNATURE		DATE		TIME		PLACE	
JAMES EARL RAY		APRIL 4, 1968		12:00 PM		MEMPHIS	
WITNESSES		SIGNATURE		DATE		TIME	
JAMES EARL RAY		JAMES EARL RAY		APRIL 4, 1968		12:00 PM	
JAMES EARL RAY		JAMES EARL RAY		APRIL 4, 1968		12:00 PM	

RECEIVED
BUREAU V. 2
JUL 12 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07093

CERTIFICATE OF DEATH

07067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
c. LENGTH OF STAY IN 1b 3yrs. 9mos. 7days				3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH First Miles Middle Anderson Last Newsome				4. DATE OF DEATH Month 7 Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 68? yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY — — —			
11. BIRTHPLACE (State or foreign country) Not given				12. CITIZEN OF WHAT COUNTRY? —			
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Syndrome		21. I certify that I attended the deceased from 7/1 , 19 57 , to 7/23 , 19 57 , that I last saw the deceased alive on 7/13 , 19 57 , and that death occurred at 3:55 AM , from the causes and on the date stated above.		22. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Baltimore, Md.		24. REC'D BY REGISTRAR DATE 1057		25. REGISTRAR'S SIGNATURE H. M. Joyce			

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

AUG 6 1957

RECEIVED

12/11/57

Received 8-2-57
J. L. Jones, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07068

Reg. Dist. No.

07094

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bar Harbor Beach, Pasadena</u>			c. LENGTH OF STAY IN 1b <u>20 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Rockview Beach P.O. Pasadena</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rock Creek</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>John</u> Last <u>Ossman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14th</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/3/08</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman at Crown Cork and Seal Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Ossman</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Navy 1938</u>		16. SOCIAL SECURITY NO. <u>213-01-0811</u>		17. INFORMANT Address <u>Mrs. Florence Ossman (wife), same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850. X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>(reach shore. Outboard motor caught on fire, jumped of the boat and failed to</u>					
20c. TIME OF INJURY Month, Day, Year <u>5.30 A. g. m. 7/14/57 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rock Creek</u>		20f. (City or town) (County) (State) <u>Bar Harbor, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>7/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hopping</u>				24a. REC'D BY REGISTRAR (24b. REGISTRAR'S SIGNATURE) <u>JUL 17 1957</u>			
ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07095

CERTIFICATE OF DEATH

07069

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>				c. LENGTH OF STAY IN lb <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Maryland</u> <u>x2 Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				d. STREET ADDRESS <u>Box 430 Wise Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSE</u> Middle <u>ELAY</u> Last <u>PACHECO JR</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/12/57</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOSE ELAY PACHECO</u>				14. MOTHER'S MAIDEN NAME <u>KATHAAYAN VINCENT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>*</u>		17. INFORMANT <u>Father, same as 2 above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>12 Jul 57</u>				20g. (County) <u>12 Jul 57</u>		20h. (State) <u>12 Jul 57</u>	
21. I certify that I attended the deceased from <u>12 July 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 July 57</u> , 19 <u>57</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold D. Fiascone</u>				ADDRESS (Street, city or town, state) <u>USA Ft. G. Meade</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD D. FIASCONE, Capt, MC</u>				DATE SIGNED <u>12 Jul</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>15 July 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. Army Hospital</u>	
22d. LOCATION (City, town, or county) <u>Ft. Geo. G. Meade Md</u>				22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Delaney CWO USA Ft. Meade</u>				ADDRESS <u>USA Ft. Meade</u>		24a. REC'D BY REGISTRAR <u>W. L. SAYLOR, 17Lt MSC</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. SAYLOR, 17Lt MSC</u>				DATE <u>13 Jul 57</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

1957 17 177

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2nd St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anthony Lamont Parker</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-1943</u>	
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		IF UNDER 24 HRS. Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Parker, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1</u>			
17. INFORMANT <u>Elizabeth Simms - East Port, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Summery in back Creek</u>							
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Summery in back Creek</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> p. m. <u>26</u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back Creek</u>				20f. (City or town) <u>Annapolis</u> (County) <u>ANCO</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from <u>Natural causes</u> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>E. Linhardt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-29-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Brower Hill</u>				22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Bryna, Md.</u>			
24a. REC'D BY REGISTRAR <u>7/29/57</u>				24b. REGISTRAR'S SIGNATURE <u>Thm J. French</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register for a burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
JUL 30 1957
BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07997

CERTIFICATE OF DEATH

Reg. Dist. No.

070718

Trans 8,9; G218 7/30/57

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drownsville		c. LENGTH OF STAY IN 1b 4yrs.3mos.5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eddie Middle Howard Last Payne		4. DATE OF DEATH Month 7 Day 22 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/99 1904
9. AGE (In years last birthday) 58 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Payne		14. MOTHER'S MAIDEN NAME (Not listed) Florence Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - -		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/11 , 19 56 to 7/22 , 19 57 , that I last saw the deceased alive on 7/21 , 19 57 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		DATE SIGNED 7/22/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7/26/57	
22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. St. Clair, Jr., Comb, Md		24a. REC'D BY REGISTRAR A. M. Jones	
ADDRESS Comb, Md		24b. REGISTRAR'S SIGNATURE A. M. Jones	

CERTIFICATE OF DEATH

NAME OF DECEASED John H. Payne		MARRIAGE None	
DATE OF DEATH July 25, 1957		PLACE OF DEATH Home	
AGE 45		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION None		PREVIOUS ILLNESS None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Payne		SIGNATURE OF WITNESSES None	
DATE OF SIGNATURE July 25, 1957		PLACE OF SIGNATURE Home	

BUREAU V. 1

JUL 25 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07098

CERTIFICATE OF DEATH

Reg. Dist. No.

07072

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Turkey Point</i>				d. STREET ADDRESS <i>1 Turkey Point</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>MABEL</i> First <i>O.</i> Middle <i>Pettit</i> Last				4. DATE OF DEATH <i>7</i> Month <i>28</i> Day <i>1957</i> Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 18, 1881</i>	
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Richard E. Owen</i>				14. MOTHER'S MAIDEN NAME <i>Anne Meredith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Charles G. Pettit, Jr.</i> Address <i>#2</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial insufficiency</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>acute egema.</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>May</i> , 19 <i>55</i> , to <i>July 28</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>July 28</i> , 19 <i>57</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D.				ADDRESS (Street, city or town, state) <i>Lothian, Md.</i> DATE SIGNED <i>7-29-57</i>			
PHYSICIAN'S NAME (Type) <i>Emily H. Wilson</i>				Lothian, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-30-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Pk.</i>		22d. LOCATION (City, town, or county) (State) <i>Falls Church Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i> ADDRESS <i>Annapolis, Md.</i>				24a. REC'D BY REGISTRAR <i>7/30/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. O'Connor</i>	

BUREAU V.

1957 31 JUL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Film 6218 7-30-57 et

07099

CERTIFICATE OF DEATH

07073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Shadyside Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Albert Pinkney</u>				4. DATE OF DEATH July 19 1957			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 1 1935</u>	
9. AGE (In years last birthday) <u>21 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Phila. George Co</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Pinkney</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>18-30-0923</u>		17. INFORMANT <u>Elizabeth A Pinkney</u> Address <u>Shadyside</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat Stroke</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epilepsy</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>931.9</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>Present</u> , 19____, that I last saw the deceased alive on <u>19 July</u> , 19 <u>57</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F D Hendricks</u> M.D.				DATE SIGNED <u>7/26/57</u>			
PHYSICIAN'S NAME (Type) <u>F D Hendricks</u>				<u>Shady Side, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Croom</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann L. Johnson</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>JUL 24 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Ann L. Johnson</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07074

07042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNEAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>L.</u> Middle <u>PLINT</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-9-1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSTALLATION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CI TELEPHONE CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>"UNK"</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS ROSEMARY PLINT</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>57</u> , to <u>7/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>57</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>7/20/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD</u>		<u>ANNAPOLIS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>7/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. 8

23 23 1957

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07075

07043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>ANNAPOLIS MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMELAND CONVASCENT HOME</u>		d. STREET ADDRESS <u>SHOONSBURY Sq.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILHELMINA</u> Middle <u>PUGH</u> Last <u>PUGH</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4 - 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>"UNK"</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>THOMAS N. VINSON</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153X INANITION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA RT COLOM METASTATIC</u> DUE TO (c) <u>6 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>00</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 1956</u> to <u>7/19, 1957</u> , that I last saw the deceased alive on <u>7/18, 1957</u> , and that death occurred at <u>9:07 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>7/22/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD ANNAPOLIS, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NAVAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons, Annapolis, Md.</u>		ADDRESS <u>41 Southgate Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE 7/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>U. Orme</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CITY OF DEATH [Faint text]		8. COUNTY OF DEATH [Faint text]		9. STATE OF DEATH [Faint text]	
10. MARITAL STATUS [Faint text]		11. OCCUPATION [Faint text]		12. CAUSE OF DEATH [Faint text]	
13. MANNER OF DEATH [Faint text]		14. MEDICAL HISTORY [Faint text]		15. HISTORY OF PRESENT ILLNESS [Faint text]	
16. SIGNATURE OF PHYSICIAN [Faint text]		17. SIGNATURE OF REGISTRAR [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]		21. SIGNATURE OF OTHER [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF NEXT OF KIN [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF NEXT OF KIN [Faint text]		27. SIGNATURE OF OTHER [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF NEXT OF KIN [Faint text]		30. SIGNATURE OF OTHER [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF NEXT OF KIN [Faint text]		33. SIGNATURE OF OTHER [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF NEXT OF KIN [Faint text]		36. SIGNATURE OF OTHER [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF NEXT OF KIN [Faint text]		39. SIGNATURE OF OTHER [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF NEXT OF KIN [Faint text]		42. SIGNATURE OF OTHER [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF NEXT OF KIN [Faint text]		45. SIGNATURE OF OTHER [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF NEXT OF KIN [Faint text]		48. SIGNATURE OF OTHER [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF NEXT OF KIN [Faint text]		51. SIGNATURE OF OTHER [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF NEXT OF KIN [Faint text]		54. SIGNATURE OF OTHER [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF NEXT OF KIN [Faint text]		57. SIGNATURE OF OTHER [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF NEXT OF KIN [Faint text]		60. SIGNATURE OF OTHER [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF NEXT OF KIN [Faint text]		63. SIGNATURE OF OTHER [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF NEXT OF KIN [Faint text]		66. SIGNATURE OF OTHER [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF NEXT OF KIN [Faint text]		69. SIGNATURE OF OTHER [Faint text]	
70. SIGNATURE OF DECEASED [Faint text]		71. SIGNATURE OF NEXT OF KIN [Faint text]		72. SIGNATURE OF OTHER [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF NEXT OF KIN [Faint text]		75. SIGNATURE OF OTHER [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF NEXT OF KIN [Faint text]		78. SIGNATURE OF OTHER [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF NEXT OF KIN [Faint text]		81. SIGNATURE OF OTHER [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF NEXT OF KIN [Faint text]		84. SIGNATURE OF OTHER [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF NEXT OF KIN [Faint text]		87. SIGNATURE OF OTHER [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF NEXT OF KIN [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF NEXT OF KIN [Faint text]		93. SIGNATURE OF OTHER [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF NEXT OF KIN [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF NEXT OF KIN [Faint text]		99. SIGNATURE OF OTHER [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF NEXT OF KIN [Faint text]		102. SIGNATURE OF OTHER [Faint text]	

BUREAU V. 8

11 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07076

Reg. Dist. No. 24

07100

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8th. Ave., N.W.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie x2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen Burnie</u>				d. STREET ADDRESS <u>8th. Ave., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>E.</u> Last <u>PUMPHREY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u>	
13. FATHER'S NAME <u>Adam Neidert</u>				14. MOTHER'S MAIDEN NAME <u>Janie Lawton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Earl Pumphrey,</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> <u>902.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive Heart Failure</u> (c) <u>Right Intertrochanteric Closed Femoral Fracture 4wks.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell from Chair</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from Chair</u>					
20c. TIME OF INJURY Month, Day, Year <u>9</u> <u>14</u> <u>June 14 19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Glen Burnie, A.A.Co., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>XX</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Sedley</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07077
21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rd. near Sudley</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Moses</u> (Roses) Last <u>Rosen</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-1942</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>a. a. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Martin Moses Riker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hoagerson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, last or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Georgia Hopkins - Anna, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>crushed skull</u> 824X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fell from truck</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:40</u> a. m. <u>July 31</u> 1957 p. m.	20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road near Sudley</u>	20f. (City or town) <u>Sudley</u> (County) <u>a. a. Co</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 2 1957</u> 24b. REGISTRAR'S SIGNATURE <u>M. J. French</u>	

AUG 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07078

Reg. Dist. No. 77

07101

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN TB 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Same			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 Box 160				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Sampson Reid				4. DATE OF DEATH Month Day Year July 31st. 1957			
5. SEX M.	6. COLOR OR RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/87		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wayne County, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Reid				14. MOTHER'S MAIDEN NAME Laura Wilder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-24-1872		17. INFORMANT Mrs. Mary Reid, (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate with generalised metastasis. DUE TO (b) metastasis. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Micro-Phtisis Anemia DUE TO (c) Micro-Phtisis Anemia							INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 292.7							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/31/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 3 1957		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Neweston Cemetery		22d. LOCATION (City, town, or county) (State) Wilson N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ridgley Selby</i>				ADDRESS 401 Wash and Laurel and		24a. REC'D BY REGISTRAR AUG 6 1957	
				24b. REGISTRAR'S SIGNATURE <i>Clara Selby</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

JUN 6 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07079

07102 CERTIFICATE OF DEATH

Item 7 FilmG217 7-12-57 et

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>ANNIE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>GREEN BURNIE</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONVI HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> TOWN STREET ADDRESS <u>RTE #1 Box 434</u>			
3. NAME OF DECEASED (First) <u>Herbert T.</u> (Middle) <u>RICHARDS</u> (Last) 4. DATE OF DEATH <u>July 6</u> 19 <u>57</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u> 8. DATE OF BIRTH <u>8/25/1908</u> 9. AGE last birthday <u>48</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PORTER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG STORE</u> 11. BIRTHPLACE (State or foreign country) <u>A.A.C., MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>ROBT. W. RICHARDS</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS <u>Marion I. Hall PASADENA MD</u>				18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 350X IMMEDIATE CAUSE (A) <u>PARKINSON'S DISEASE</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?				22. I hereby certify that I attended the deceased from <u>Jan 1957</u> , to <u>July 6, 57</u> , that I last saw the deceased alive on <u>June 25, 57</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Joseph A. Hall</u> M.D. ADDRESS (Street, city, town, state) <u>102 Baltimore Ave. Green Burnie, Md. 7-6-7</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> DATE THEREOF <u>7/10/57</u> NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church</u> LOCATION (City, town, or county) (State) <u>MAGOOTHY, A.A.C., MD</u>				24. REC'D BY REGISTRAR <u>VS</u> REGISTRAR'S SIGNATURE <u>Marshall P. Hays</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>638 N. GUMMOT</u> ADDRESS			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. PLACE OF DEATH

HOME

RESIDENCE

1011 17th St NW

DATE OF DEATH

8/22/1908

AGE 48

WHITE (COLOR)

MARRIED (MARRIAGE)

FOSTER

FOOT. W. F. CHARD

100

BUREAU V. S.

JUL 9 1907

RECEIVED

Received by Mr. J. C. Church

07103

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anna Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anna Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Odenton, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Rural Odenton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Grove Rd.</u>				d. STREET ADDRESS <u>1 Jackson Grove Rd.</u>			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Larry</u> First <u>Russell</u> Middle <u>Rivers</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1908</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus Rivers</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>217-01-6655</u>		17. INFORMANT Address <u>Mrs Agnes M. Rivers Severn, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> <u>162x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis (Cerebral Metastasis)</u> DUE TO (c) <u>Right Bronchogenic Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rt Pneumonitis & Pleural Effusion 12/56; Expt Thoracotomy 5/57</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/7/57</u> , 19 <u>57</u> , to <u>7/11/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/7/57</u> , 19 <u>57</u> , and that death occurred at <u>7/11/57</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>113 7th Ave Brookline Park Balt 25, Md</u> DATE SIGNED <u>7/11/57</u>							
ACTUAL SIGNATURE <u>Lemard H. Flax MD</u> M.D. <u>7/11/57</u>							
PHYSICIAN'S NAME (Type) <u>Leonard H. Flax, M.D.</u> <u>113 7th Ave Brookline Park Balt 25, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore St.</u>				24a. REC'D BY REGISTRAR <u>JUL 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Lara Hashiguchi</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07081
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 21
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Baltimore (25)</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel County Jail</u>					d. STREET ADDRESS <u>236 Bishop Ave Patapsco Park</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Lee Russell</u>					4. DATE OF DEATH Month Day Year <u>July 9, 19 57</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN</u>		9. AGE (In years last birthday) <u>23</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In general</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Weldon Russell</u>					14. MOTHER'S MAIDEN NAME <u>Blanche ?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>WW II</u>		17. INFORMANT <u>Margaret Russell</u>		Address <u>Same</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic alcoholism</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fatty infiltration of liver</u> (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.1</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D. EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/9/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat. Cem</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1000 Brantley Ave</u>					24a. REC'D BY REGISTRAR DATE <u>JUL 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thos J. French</u>			

MAINTAINING STATE DEPARTMENT OF HEALTH - BATHING MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Anne Arundel General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>Sabel</i> Last <i>Sabel</i>		4. DATE OF DEATH Month <i>July</i> Day <i>12</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-26-1893</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months <i>63</i> Days <i>63</i> Hours <i>63</i> Min.	IF UNDER 24 HRS. Hours <i>63</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nursing</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>AARON SABEL</i>		14. MOTHER'S MAIDEN NAME <i>ROSEMARY PINCUS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Lida Sabel</i>		Address <i># 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (b) <i>Heart</i> (a), stating the underlying cause lost. DUE TO (c) <i>Heart</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>F. L. W. Hardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>F. L. W. Hardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6-12-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-15-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>7/15/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. D. Prince</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *James J. [illegible]*
AGE: *45* SEX: *M*
DATE OF DEATH: *July 12, 1957*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *[illegible]*
DATE: *July 12, 1957*

BUREAU V. 3

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shore Acres, P.O. Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
c. LENGTH OF STAY IN 1b <u>3hrs.</u>		d. STREET ADDRESS <u>6103 Chinkuapin Park Way</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Thomas Schenk Schek</u>		4. DATE OF DEATH Month Day Year <u>July 14th. 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/4/30</u>
9. AGE (In years last birthday) <u>27 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Clerk Bendix Radio</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles William Schek</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gertrude Schmoll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 1951-52</u>		16. SOCIAL SECURITY NO. <u>212-28-2314</u>	
17. INFORMANT <u>Mrs. M.G. Schek (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850. X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>850. X</u> (c) <u>850. X</u> DUE TO cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off boat and drowned.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3.15</u> a. m. <u>7/14/57</u> 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>	20f. (City or town) (County) (State) <u>Shore Acres, A.A. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>7/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/17/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>7/18/57</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Ruck</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Smoking Habits

Family History

Personal History

Autopsy

Disposition

Remarks

Signature

Witness

Coroner

Registrar

Physician

Nurse

Pathologist

Forensic Scientist

Medical Examiner

Medical Director

Medical Officer

Medical Assistant

Medical Secretary

Medical Receptionist

Medical Clerk

Medical Janitor

Medical Cook

Medical Steward

Medical Porter

Medical Attendant

Medical Aide

Medical Helper

Medical Trainee

Medical Student

Medical Intern

Medical Resident

Medical Fellow

Medical Professor

Medical Lecturer

Medical Researcher

Medical Writer

Medical Editor

Medical Publisher

Medical Distributor

Medical Supplier

Medical Manufacturer

Medical Importer

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Medical Agent

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07106

CERTIFICATE OF DEATH

Reg. Dist. No.

07084

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOK PK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>600 HAMMONDS LANE</u>				1 d. STREET ADDRESS <u>600 HAMMONDS LANE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN J. SEIFERT</u>				4. DATE OF DEATH Month Day Year <u>JULY 10 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FLORIST</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK SEIFERT</u>				14. MOTHER'S MAIDEN NAME <u>HELEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. HELEN SCHICTON 600 HAMMONDS LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lung Cancer</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>9-10-57</u> <u>10-10-57</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>July 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-10</u> , 19 <u>57</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew R. Sosnowski</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>4016 Ritchie Hwy Balt 25 10/10/57</u>			
PHYSICIAN'S NAME (Type) <u>Andrew R. Sosnowski M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE HWY. A.A. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George J. Rone 4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR DATE <u>7/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Ida Whitson</u>	

07107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN lb 2yrs. 8mos. 3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 313 W. Preston Street			
3. NAME OF DECEASED (Type or print) First James Middle Simms Last Simms				4. DATE OF DEATH Month 7 Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/06	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME George Henry Cornish				14. MOTHER'S MAIDEN NAME Annie Louise Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Crownsville State Hospital Hospital Records Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Modified Heat Reaction DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the Liver and Syphilis 571.8							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/6 19 56 , to 7/21 19 57 , that I last saw the deceased alive on 7/2 19 57 , and that death occurred at 11:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 7/22/57							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.				PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-21-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frances A. Hensley ADDRESS 578 W. Biddle St.				4a. REC'D BY REGISTRAR ST-1 DATE 23 1957		24b. REGISTRAR'S SIGNATURE K.M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JUL 23 1957

RECEIVED

07046

CERTIFICATE OF DEATH

Reg. Dist. No.

07086

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hosp.</u>				d. STREET ADDRESS <u>St 1 Bldg 209</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Simms</u> Middle <u>Simms</u> Last				4. DATE OF DEATH <u>7</u> Month <u>17</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoeland Beach Edgewater, Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S. Ill.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. Ill.</u>			
13. FATHER'S NAME <u>George Simms</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Address</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>795.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>795.0</u> DUE TO (c) <u>795.0</u> DUE TO							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-15-57</u> , 19 <u>57</u> , to <u>7-17-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-17-57</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.T. Allen</u> M.D.				DATE SIGNED <u>7-18-57</u>			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>				ADDRESS (Street, city or town, state) <u>Annapolis Md</u>			
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dopes Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 29 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>John J. Lynch</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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JUL 30 1957

Dr. J. H. Smith - 7-20-21
J. H. Smith - 7-20-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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07108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
c. LENGTH OF STAY IN 1b 2yrs.2mos.28days				3v01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 712 Dophin Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Columbus Middle Smith Last Smith				4. DATE OF DEATH Month 7 Day 25 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/23/03	
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook and Bell Hop				10b. KIND OF BUSINESS OR INDUSTRY — —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Henry Smith				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) — —		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Failure DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 522x				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 57 , to 7/25 , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 3:30a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Conwell Newton M.D.				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 7/25/57	
PHYSICIAN'S NAME (Type) Conwell Newton							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF 7/29/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Hemaly				24a. REC'D BY REGISTRAR 578 W. Biddle St.		24b. REGISTRAR'S SIGNATURE L. M. Jayce	

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

070878

07109

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3mos.10days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Somerville Last Somerville				4. DATE OF DEATH Month 7 Day 7 Year 19 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/99		9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given		10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Levy Harding				14. MOTHER'S MAIDEN NAME Maggie Harding BROCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Tuberculosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/28 , 19 57 , to 7/7 , 19 57 , that I last saw the deceased alive on 7/7 , 19 57 , and that death occurred at 4:55pM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.				ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 7/8/57			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
		7/11/57		Guilford Baptist Church Guilford Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.C. Higginbotham				ADDRESS Chesapeake City Md.		24a. REC'D BY REGISTRAR JUL 10 1957 DATE 24b. REGISTRAR'S SIGNATURE A. M. Joyce	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07110 CERTIFICATE OF DEATH

07088

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY Anna Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 30 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route No. 9, Box 144				d. STREET ADDRESS 2241 Cedley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MATTIE ELIZABETH SPRINKEL				4. DATE OF DEATH JULY 25 Day Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 25, 1888 68 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Bond				14. MOTHER'S MAIDEN NAME Henrietta Posey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Norma E. Koepf 2241 Cedly St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA COLON 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1 ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/25 , 19 57 , to 7/25 , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 2:00 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Brady Smith M.D.				ADDRESS (Street, city or town, state) Riviera Beach, Md.		DATE SIGNED 7/26/57	
PHYSICIAN'S NAME (Type) J. BRADY SMITH				RIVIERA BEACH, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Trinty Church Cem.		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Fred. A. Cole ADDRESS 1913 W. Baltimore St., 23				24a. REC'D BY REGISTRAR DATE 29 1957		24b. REGISTRAR'S SIGNATURE L. J. Delaney	

CERTIFICATE OF DEATH

Name of Deceased George Bond		Sex Male		Age 65	
Date of Birth 1892		Place of Birth Maryland		Race White	
Usual Residence Route No. 2, Box 142		Manner of Death Natural		Cause of Death Heart Disease	
Occupation Farmer		Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Death July 29, 1957		Place of Death Home		County Anne Arundel	
City Pocomoke		State Maryland		District 1	
Burial Place Pocomoke Cemetery		Burial Date August 1, 1957		Burial Place Pocomoke Cemetery	
Name of Informant Mrs. Norma E. Knapp		Relationship Wife		Address Pocomoke, Md.	
Signature of Informant [Signature]		Signature of Registrar [Signature]		Signature of Physician [Signature]	
Date of Report August 1, 1957		Place of Report Pocomoke		County Anne Arundel	
City Pocomoke		State Maryland		District 1	
Burial Place Pocomoke Cemetery		Burial Date August 1, 1957		Burial Place Pocomoke Cemetery	

BUREAU V. 3

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07090

07047

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General		d. STREET ADDRESS 14 Munroe Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADELINE Middle P Last STEHLE		4. DATE OF DEATH Month JULY Day 11 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Polyanski		14. MOTHER'S MAIDEN NAME Josephine Kuyawa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr John Stehle- Husband- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs + 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1954 to July 11, 1957 , that I last saw the deceased alive on 7-11-1957 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw Street Annapolis, Maryland DATE SIGNED 7-15-57			
ACTUAL SIGNATURE James R. Martin M.D.			
PHYSICIAN'S NAME (Type) James R. Martin M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JUL 16 1957	
24b. REGISTRAR'S SIGNATURE Am. J. Lench			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

417074

DECEMBER

JUL 16 1957

RECEIVED

07048

CERTIFICATE OF DEATH

07091

Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 14 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 258 West Street				d. STREET ADDRESS 258 West Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Norman R. Sweeney				4. DATE OF DEATH Month Day Year July 14, 1957.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1915		9. AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Empld.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Norman F. Sweeney				14. MOTHER'S MAIDEN NAME Idella Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-22-3373		17. INFORMANT Mrs. Idella Sweeney-same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Brain 193x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to July 14, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Md. DATE SIGNED 7/14/57 ACTUAL SIGNATURE Maurice F. Klawans, M.D. PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/57		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JUL 23 1957	
				24b. REGISTRAR'S SIGNATURE John J. Lenchy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	

RECEIVED
 JUL 23 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07092
21

Reg. Dist. No.

07049

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			
				d. STREET ADDRESS 1 South River Park			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR BOYD TRAYLOR				4. DATE OF DEATH Month Day Year July 3 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8, 1915	
				9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Police		11. BIRTHPLACE (State or foreign country) Biloxi, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. Mills Traylor				14. MOTHER'S MAIDEN NAME Lillian Stephens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 353-09-5093		17. INFORMANT Address Mrs. Barbara S. Traylor- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of Lung c Hemo Phumo throat 857.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH Sudden</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture neck</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) outboard motor exploded-section of which penetrated the left thoracic cavity- section was 6in x 2 1/2 in and was 3/8 in thick					
20c. TIME OF INJURY Month, Day, Year 7:05 p.m. 7-3-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) South River		20f. (City or town) (County) (State) Edgewater, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Elmer G. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 4, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince George County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> Hopping Funeral Home				24a. REC'D BY REGISTRAR W.L. 8 1957			
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Residence	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

Description of Injury or Disease		Time of Death		Place of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

BUREAU V. 3

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07050

CERTIFICATE OF DEATH

07093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND ANNE ARUNDEL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b NEWBORN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 4506 Garrison Boulevard			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Dorothea Middle Lorraine Last TRUST				4. DATE OF DEATH Month July Day 26 Year 1957			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 July 1957	
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months 40		IF UNDER 24 HRS. Hours 2 Min. 40			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME ROBERT WAKEFIELD TRUST				14. MOTHER'S MAIDEN NAME JEAN MILDRED LAMKIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address U.S. Naval Hospital, Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 761.5 IMMEDIATE CAUSE (a) ASPHYXIATION DUE TO Incomplete expansion of lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity & Immaturity (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
INTERVAL BETWEEN ONSET AND DEATH 3 Hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from 26 July , 19 57 , to 26 July , 19 57 , that I last saw the deceased alive on 26 July , 19 57 , and that death occurred at 2:24 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S.N. Hospital, Annapolis, Md. DATE SIGNED 7-26-57							
ACTUAL SIGNATURE Luis A. Morales				M.D. U.S.N. Hospital, Annapolis, Md.			
PHYSICIAN'S NAME (Type) LUIS A. MORALES LCDR MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-57		22c. NAME OF CEMETERY OR CREMATORY HIGHLAND CREST		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Long & Sons				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 7/30/57	
24b. REGISTRAR'S SIGNATURE J. J. ...							

2051233XVO

RECEIVED
JUL 31 1957
BUREAU # 1

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARUEL BEACH</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>170 CARUEL BEACH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>170 CARUEL BEACH RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Tucker</u> First Middle Last				4. DATE OF DEATH <u>7-24</u> Month Day Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Albee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>315077684</u>		17. INFORMANT <u>Family - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of right lower jaw</u> <u>199.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and glottis (mandibula)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>795.0</u> <u>MARASHUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1957</u> to <u>July 24, 1957</u> , that I last saw the deceased alive on <u>7-20</u> , 1957, and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Otto Vogel</u> M.D.				DATE SIGNED <u>7-24-57</u>			
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem. Balto</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes Balto Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUL 26 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>L. J. Seabury</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 26 1957

RECEIVED

07095

07112

CERTIFICATE OF DEATH

Reg. Dist. No.

25

MEDICAL CERTIFICATION	1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		c. LENGTH OF STAY IN lb <u>4 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN</u>			
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>224 ORCHARD AVE.</u>				d. STREET ADDRESS <u>1224 ORCHARD AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) First Middle Last <u>NICHLAUS T. VON HAGEL</u>			4. DATE OF DEATH Month Day Year <u>JULY 30 1957</u>				
	5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23, 1913</u>	9. AGE (In years lost birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REVERE COPPER BALTO, MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
	13. FATHER'S NAME <u>NICHLAUS T. VON HAGEL</u>			14. MOTHER'S MAIDEN NAME <u>ANNA V. DAILEY</u>				
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>212-10-2884</u>		17. INFORMANT Address <u>MRS LORRETTA VON HAGEL</u>		<u>SAME</u>	
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 months</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
	20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>7-29</u> , 19 <u>57</u> , to <u>7-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>P. J. Grimaldi</u> M.D. ADDRESS (Street, city or town, state) <u>4609 G.W. Ritchie Highway</u> DATE SIGNED <u>Aug 5, 1957</u> PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI M.D.</u> <u>Balto - 25, Md.</u>								
	22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 3, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hwy., A.A.C., MD</u>			
	23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gorce</u>				ADDRESS <u>4001 RITCHIE Hwy.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 5 1957</u>	24b. REGISTRAR'S SIGNATURE <u>McMillan</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1910</i>		6. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
7. DATE OF DEATH <i>Aug 10 1957</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:00 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. DISEASE OR INJURY <i>Myocardial Infarction</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF WITNESSES <i>Mr. & Mrs. Doe</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. NAME OF FUNERAL HOME <i>John Doe</i>		18. NAME OF CEMETERY <i>John Doe</i>	
19. NAME OF BURIAL PLACE <i>John Doe</i>		20. NAME OF INTERMENT <i>John Doe</i>	
21. NAME OF CREMATOR <i>John Doe</i>		22. NAME OF CREMATION <i>John Doe</i>	
23. NAME OF INCINERATOR <i>John Doe</i>		24. NAME OF INCINERATION <i>John Doe</i>	
25. NAME OF BURIAL PLACE <i>John Doe</i>		26. NAME OF INTERMENT <i>John Doe</i>	
27. NAME OF CREMATOR <i>John Doe</i>		28. NAME OF CREMATION <i>John Doe</i>	
29. NAME OF INCINERATOR <i>John Doe</i>		30. NAME OF INCINERATION <i>John Doe</i>	

BUREAU V. S.

AUG 6 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07096

C7051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Deale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HA General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Agnes Elizabeth Walker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 4 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug 25 1864</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pares Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Charles Walton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Kellie Ford, Upper Marlboro Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>central accident</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>3/31/57</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 3, 1957</u> to <u>July 4, 1957</u> that I last saw the deceased alive on <u>July 3, 1957</u> and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily A. Wilson</u>				ADDRESS (Street, city, town, state) <u>College, Md.</u>		DATE SIGNED <u>7-6-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/5/57</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>St. Mary's, Md.</u>	
24. REC'D BY REGISTRAR <u>7/9/57</u>		REGISTRAR'S SIGNATURE <u>V. J. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ramond Hardisty</u>		ADDRESS <u>Salvatore</u>	

CERTIFICATE OF DEATH

REGISTRATION NUMBER

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTY

DECEASED

NAME OF DECEASED
AGE
SEX
RACE
MARRIAGE

DATE OF BIRTH
PLACE OF BIRTH
CITY
STATE
COUNTY

DECEASED

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NAME OF DECEASED
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BUREAU V. S.

UL 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07097

Reg. Dist. No.

07113

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Station, P.O. Arnold</u> c. LENGTH OF STAY IN Tb <u>Few seconds.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Severna Park</u> d. STREET ADDRESS <u>Route 1 Box 211-A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ray Lawrence Walsh</u>		4. DATE OF DEATH Month Day Year <u>July 20th. 19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/18/16</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Helper Stark Electric</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marion, N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence B. Walsh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Isabel Padgett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>238-14-9559</u>	
17. INFORMANT <u>Julian M. Dixon (brother in law)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, Comm. Comp. fracture of left</u> <u>8/2X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>leg. Multiple disseminated abrasions over face and</u> DUE TO (c) <u>body.</u> Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was crossing highway when was hit by an automobile.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9.50</u> o. m. <u>7/20/57</u> 19 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 2</u>	20f. (City or town) (County) (State) <u>P.O. Arnold, A.A. Maryland.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 20th. 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 24, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Marion, North Carolina</u>	22d. LOCATION (City, town, or county) (State) <u>Marion, North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 23 1957</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Sallapas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07098

C7052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Warner</u> Last <u>Warner</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1864</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas D. Barry</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Storm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mabel W. Griffiths</u> Address <u>#2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Pulmonary Edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>C de compensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/26</u> , 19 <u>57</u> , to <u>7/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Ave Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE E. KLAWANS</u>		DATE SIGNED <u>7/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stroudsburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Stroudsburg Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sono Annapolis</u>		24a. REC'D BY REGISTRAR <u>7/8/57</u>	24b. REGISTRAR'S SIGNATURE

07114 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

07099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Millersville</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elvaton</u>				d. STREET ADDRESS <u>1 Same</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William August</u> Middle <u>Wasserman</u> Last <u></u>				4. DATE OF DEATH Month <u>July</u> Day <u>29th.</u> Year <u>19 57</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/72</u> <u>Baltimore, Md.</u>	9. AGE (In years last birthday) <u>85</u> yrs.	10. UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Furniture finisher Potash Bros.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wasserman</u>				14. MOTHER'S MAIDEN NAME <u>Regina Newcombe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-3518</u>		17. INFORMANT Address <u>Miss M. Wasserman (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>June 19 52</u> to <u>July 29th 19 57</u> , that I last saw the deceased alive on <u>July 29th 19 57</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							DATE SIGNED <u>7/29/57</u>
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. <u>Glen Burnie, Md.</u>			ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. [illegible]</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 2 1957</u>	24b. REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

AUG 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G218 7-19-57 et

CERTIFICATE OF DEATH

07115

Reg. Dist. No.

07100 28
261

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Marshall Station Somerset Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	c. LENGTH OF STAY IN <u>1b</u> <u>9 months 8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marshall Station 19x22</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>S.</u> Last <u>WATERS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>VINCENT WATERS</u>		14. MOTHER'S MAIDEN NAME <u>Annie Boggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 5</u> , 19 <u>56</u> , to <u>July 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>57</u> , and that death occurred at <u>110</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>L. Benedict</u> M.D.		PHYSICIAN'S NAME (Type) <u>Ludwig BENEDIKT Crownsville State Hosp.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 17 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Marion Station</u>	22d. LOCATION (City or town, county, state) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>MARION STA MD</u>		24a. REC'D BY REGISTRAR DATE <u>7-15-57</u>	24b. REGISTRAR'S SIGNATURE <u>Kellie R. Payne</u> <u>J. M. Goyan</u>

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED <i>WILLIAM J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>July 17, 1957</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Retired</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
16. SIGNATURE OF DECEASED <i>None</i>		17. SIGNATURE OF WITNESSES <i>None</i>		18. SIGNATURE OF REGISTRAR <i>None</i>	

BUREAU V. 2

JUL 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0710128

07116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3mos. 27days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberstone	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1 None listed		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Watkins				4. DATE OF DEATH Month 7 Day 8 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/04	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Alexander Hicks				14. MOTHER'S MAIDEN NAME Mary Elizabeth Hicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia and Cysto-pyelitis 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningiome DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers 6080 INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/13 , 19 57 , to 7/8 , 19 57 , that I last saw the deceased alive on 7/8 , 19 57 , and that death occurred at 10:50a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 7/8/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-11-57		Chews Chapel		Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Deese				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 10 1957	
24b. REGISTRAR'S SIGNATURE K. M. Joyce							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. S.

JUL 10 1957

RECEIVED

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1912		New York City	
Usual Residence		Marital Status		Cause of Death		Date of Death		Place of Death	
123 Main St, Baltimore		Married		Heart Disease		July 8, 1957		Baltimore	
Occupation		Education		Manner of Death		Physician's Signature		Hospital or Institution	
Teacher		High School		Natural		[Signature]		None	
Previous Illnesses		Alcohol Consumption		Toxicology		Burial or Disposition		Burial Place	
None		Occasional		None		Buried		Catholic Cemetery	
Signature of Informant		Relationship to Deceased		Informant's Signature		Informant's Address		Informant's Phone	
[Signature]		Wife		[Signature]		123 Main St		[Phone]	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>10yrs.10mo.4da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				d. STREET ADDRESS <u>Cambridge, Maryland</u> 0913.2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>WESTON</u>				4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Weston</u>				14. MOTHER'S MAIDEN NAME <u>Grace Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address <u>Hospital Records Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Tuberculosis (Far Advanced)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Syphilis of the Central Nervous System</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>3-11-57</u> , 19 <u>57</u> , to <u>7-30-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-30-57</u> , 19 <u>57</u> , and that death occurred at <u>1:30 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u>		DATE SIGNED <u>7-30-57</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>							
22a. BURIAL, CREMATION		22b. DATE THEREOF <u>8-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mirrored and difficult to read.

BUREAU V. 2

AUG 6 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page, including a date "8-22-57" and a signature.

07118

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto City 3401-4			
c. LENGTH OF STAY IN 1b 12 y-lm-9days				d. STREET ADDRESS 909 Arlington Av.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elma			4. DATE OF DEATH Month 7 Day 26 Year 1957				
5. SEX F		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown 1904	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 7 Days 26 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) unknown Balto-MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown Harry Wheeler		14. MOTHER'S MAIDEN NAME unknown Julia Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital records and Harry A. Wheeler, Balto.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mitral stenosis and insufficiency DUE TO (c) chron. endocarditis of the mitral valve						INTERVAL BETWEEN ONSET AND DEATH 24 hr. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 301.1 Manic Depressive Psychosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/18/45	
20f. (City or town) 11/26/57				20g. (County) 11/30		20h. (State) 11/30	
21. I certify that I attended the deceased from 6/18/45 to 11/26/57 , that I last saw the deceased alive on 11/26/57 , and that death occurred at 11/30 M, from the causes and on the date stated above. P ADDRESS (Street, city or town, state) Balto Md DATE SIGNED Dr. Ludwig Benedict							
ACTUAL SIGNATURE Dr. Ludwig Benedict M.D.				PHYSICIAN'S NAME (Type) Dr. Ludwig Benedict, Crownsville State Hospital, Crownsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7/6/1957		22c. NAME OF CEMETERY OR CREMATORY mt auburn		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes				24a. REC'D BY REGISTRAR DATE 11 29 1957		24b. REGISTRAR'S SIGNATURE X. M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: *Harry Wheeler*
AGE: *40*
SEX: *M*
RACE: *W*
DATE OF BIRTH: *1904*
PLACE OF BIRTH: *At Home*
OCCUPATION: *Electrician*
CAUSE OF DEATH: *Myocardial infarction*
DATE OF DEATH: *July 20, 1957*
PLACE OF DEATH: *At Home*
SIGNATURE: *[Signature]*
DATE: *July 20, 1957*

BUREAU A. 3

JUL 30 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page.

CERTIFICATE OF DEATH

Reg. Dist. No.

07119

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Waterbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELSIE Middle M Last WILLIAMS		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-reacher		10b. KIND OF BUSINESS OR INDUSTRY US Gov.	
11. BIRTHPLACE (State or foreign country) Waterbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME R. Thomas Williams		14. MOTHER'S MAIDEN NAME Frances Bryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Helen D. Tindall-		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct , 1946, to July 2 , 1957, that I last saw the deceased alive on June 29 , 1957, and that death occurred at 2 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward G. Skerritt		ADDRESS (Street, city or town, state) Gambrills Md	
DATE SIGNED 7-2-57			
PHYSICIAN'S NAME (Type) Edward G. Skerritt MD		Gambrills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 5, 1957	22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cem.	22d. LOCATION (City, town, or county) (State) Millersville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR 8 1957		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 8 JUL

RECEIVED

07120

CERTIFICATE OF DEATH

Reg. Dist. No.

25

I. NAME OF DECEASED
(Type or Print)

FRANK WOJCIECHOWSKI

2. DATE
OF
DEATH

July 8 1957

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

311 6th Ave.

C. CITY OR TOWN

If outside corporate limits, write RURAL and give township)

Brooklyn Md. 50

D. STREET ADDRESS (If rural, give location)

311 6th Ave. 1

C. Length of stay in Baltimore

Lifetime

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 29 1907 50

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Wojciechowski

14. MOTHER'S MAIDEN NAME

Francis Givaski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-03-4902

17. INFORMANT

Mrs. Wojciechowski

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Intestinal Cancer

DUE TO

7 July 57

8 July 57

163X ANTECEDENT CAUSES

(B)

Carcinoma of Lung

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from April 11 1957 to July 8 1957, that (I) (we) last saw the deceased alive on July 7 1957, and that death occurred at 4 A.M. m., from the causes and on the date stated above.

23A. SIGNATURE

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐

M.D.

23B. ADDRESS

4016 Bletcher Hing

23C. DATE SIGNED

10 July 57

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 11 1957

Holy Cross Cem

Brooklyn Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

7/10/57

L. Whitson

Charles F. Dill 15018 Fort Ave.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg

HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

BUREAU V-4

JUL 12 1957

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RECEIVED FOR BUREAU V-4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07121

CERTIFICATE OF DEATH

0710728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN b 5yrs. 5mos. 14days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 708 N. Vincent Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Abraham Middle Wormley Last Wormley				4. DATE OF DEATH Month 7 Day 14 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given	9. AGE (In years last birthday) 76?	IF UNDER 1 YEAR Months 7 Days 14 Hours 57	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not listed		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Kent Bm Co Va		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walker Wormley				14. MOTHER'S MAIDEN NAME Jane Montague			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or date of service) Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Softening of the brain 332X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , to 7/14 , 19 56 , to 7/14 , 19 57 , that I last saw the deceased alive on 7/14 , 19 57 , and that death occurred at 6:45 p. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/15/57							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.				PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Type)		22b. DATE THEREOF 7/18/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan Jr				ADDRESS Balto		24a. REC'D BY REGISTRAR DATE 7/18/57	
				24b. REGISTRAR'S SIGNATURE R. M. J. J.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. S.

RECEIVED

7957 64 700

07122

CERTIFICATE OF DEATH

Reg. Dist. No.....

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Friendship</u>		<u>1 yr.</u>		TOWN <u>Friendship</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u>		(Middle) <u>ARTHUR</u>		(Last) <u>YORK</u>		(Month) <u>July</u> (Day) <u>20</u> (Year) <u>1957</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>male</u>	<u>white</u>	<u>married</u>	<u>July 31, 1893</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Physician</u>					<u>Tennessee</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Milton York</u>				<u>Anna Schubert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>W. W. I.</u>		<u>214-38-6191</u>		<u>W. H. York</u> <u>Princeton, N. J.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26, 1957</u> to <u>July 20, 1957</u> , that I last saw the deceased alive on <u>July 20, 1957</u> , and that death occurred at <u>5:25 PM</u> from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>[Signature]</u>		<u>[Signature]</u>		<u>Friendship, Md.</u>		<u>11/20/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 23, 57</u>		<u>Friendship Cemetery</u>		<u>Friendship Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>	
DATE <u>7/28/57</u>		<u>[Signature]</u>		<u>[Signature]</u>			

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